SUMMARY: This document contains final regulations relating to the imposition of the heavy vehicle use tax on foreign-based highway motor vehicles. Changes to the applicable law were made by the Surface Transportation and Uniform Relocation Assistance Act of 1987. The regulations affect owners of highway motor vehicles that have a base for registration purposes in a contiguous foreign country and provide them with the guidance needed to comply with the law.

DATES: The regulations are effective for taxable periods beginning after June 30, 1987.

FOR FURTHER INFORMATION CONTACT: William A. Jackson of the Legislation and Regulations Division, Office of the Chief Counsel, Internal Revenue Service, 1111 Constitution Avenue, NW., Washington, DC 20224, Attention: CC:LR:T (LR–33–87) (202) 566–3287, not a toll-free call.

SUPPLEMENTARY INFORMATION:

Background

On September 4, 1987, the **Federal Register** published a notice of proposed rulemaking proposing amendments to the Excise Tax Regulations (26 CFR Part 41) under sections 4481, 4483, 6001, and 6091 of the Internal Revenue Code of 1986 (Code) (52 FR 33602) by cross-reference to temporary regulations published the same day in the **Federal Register** (52 FR 33583). These amendments were proposed to conform the regulations to section 507 of the Highway Revenue Act of 1987 (Title V of the Surface Transportation and Uniform Relocation Assistance Act of 1987) (Pub. L. 100–17, 101 Stat. 260) which imposed the heavy vehicle use tax under section 4481 of the Code on foreign-based highway motor vehicles. The Internal Revenue Service did not receive any comments on the proposed regulations. No public hearing was requested or held. For this reason, the final regulations adopt the temporary regulations without any substantive changes.

Special Analysis

It has been determined that this regulation will not have a significant impact on a substantial number of small entities. The number of small entities affected is minimal. Accordingly, these final regulations are not subject to the Regulatory Flexibility Act of 1980 (5 U.S.C. Chapter 6). The Commissioner of Internal Revenue has determined that this regulation is not a major rule as defined in Executive Order 12291 and that a regulatory impact analysis therefore is not required.

Paperwork Reduction Act

The collection of information requirements contained in these regulations have been submitted to the Office of Management and Budget (OMB) for review under the Paperwork Reduction Act of 1980. These regulations have been approved by OMB.

Drafting Information

The principal author of these regulations is William A. Jackson of the Legislation and Regulations Division of the Office of Chief Counsel, Internal Revenue Service. However, personnel from other offices of the Internal Revenue Service and Treasury Department participated in developing the regulations both on matters of substance and style.

List of Subjects in 26 CFR Part 41

Excise taxes, Motor vehicles.

Adoption of Amendments to the Regulations

Accordingly, 26 CFR Part 41 is amended as follows:

Paragraph 1. The authority for Part 41 is amended by removing the citation for § 41.6001–3T, and adding the following citation:

Authority: 26 U.S.C. 7805. * * * Section 41.6001–3 also issued under 101 Stat. 260.

Par. 2. Temporary regulations § 41.4483–7T and § 41.6001–3T, as published on September 4, 1987, in 52 FR 33583, are adopted as final regulations; the new sections are redesignated as § 41.4483–7 and § 41.6001–3, respectively.

Par. 3. In paragraph(a)(2)(ii) of § 41.4481–1, the language "§ 4.4483–7T" is removed and the language "§ 41.4483–7" is added in its place.

Lawrence B. Gibbs,

Commissioner of Internal Revenue.

Approved: February 9, 1988.

Donaldson Chapoton,

Assistant Secretary of the Treasury.

[[FR Doc. 88–4448 Filed 3–1–88; 8:45 am]

BILLING CODE 4830–01–M

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26 CFR Part 51

[T.D. 8185]

Excise Tax Regulations Under the Crude Oil Windfall Profit Tax Act of 1980; Newly Discovered Oil

AGENCY: Internal Revenue Service, Treasury.

ACTION: Final regulations.

SUMMARY: This document provides final excise tax regulations relating to the definition of the term "newly discovered oil" for purposes of the windfall profit tax. Changes to the applicable tax law were made by the Crude Oil Windfall Profit Tax Act of 1980, by the Economic Recovery Tax Act of 1981, and by the Tax Reform Act of 1986. The final requirements provide guidance on the requirements for the qualification of crude oil as newly discovered oil, as well as a definition of production in "commercial quantities" that affects the definition of property, the net income limitation on windfall profit, and the exemption for Alaskan oil.

DATE: The final regulations are effective with respect to all crude oil removed (or deemed removed) from the premises after February 29, 1980.

FOR FURTHER INFORMATION CONTACT: David R. Haglund of the Legislation and Regulations Division, Office of Chief Counsel, Internal Revenue Service, 1111 Constitution Avenue NW., Washington, DC 20224 (Attention: CC:LR:T) (202–566–3297).

SUPPLEMENTARY INFORMATION:

Background

On November 5, 1982, the **Federal Register** published proposed amendments to the Excise Tax Regulations Under the Crude Oil Windfall Profit Tax Act of 1980 (26 CFR Part 51) under sections 4988, 4991, and 4996 of the Internal Revenue Code of 1954 (47 FR 50306). The amendments were proposed to conform the regulations to section 101(a)(1) of the Crude Oil Windfall Profit Tax Act of 1980 (94 Stat. 230). A public hearing was held in April 12, 1983. After consideration of all comments regarding the proposed amendments, those amendments are adopted as revised by this Treasury decision.

Explanation of Provisions

Commercial Quantities—In General

The Conference Committee Report accompanying the Crude Oil Windfall Profit Tax Act of 1980 (Rep. No. 817, 96th Cong., 2d Sess. 97–8 (1980)) stated that it was the intention of the Committee that the term "newly discovered oil" should include production from a property that did not produce crude oil in commercial quantities in calendar year 1978. The report stated that this included production from a property on which oil was produced in 1978 if that 1978 production was incident to the drilling of exploratory or test wells and was not part of continuous or commercial production.

The proposed regulations defined crude oil produced in "commercial

quantities" as any crude oil production (1) sold or exchanged or (2) retained for beneficial economic use by the operator or by any producer. However, crude oil produced incident to the drilling of an exploratory well (including a test well) was to be disregarded. The proposed regulations also provided that in no case would crude oil produced from a well after its casing, including the so-called "Christmas tree," had been installed be considered to be crude oil produced incident to such drilling.

Comments submitted with respect to the proposed rule pointed out that the rule did not conform to industry practices. In many instances installation of casing and a flow control device are required in order to comply with environmental and conservation practices, and such installation is not necessarily evidence of the termination of the "exploration" phase. As a result, the final regulations modify the position taken in the proposed regulations by adopting the rule stated in the conference report. Under this rule, the determination of each particular case is based solely on the facts and circumstances of that case.

Commercial Quantities—Newly Discovered Oil

For the purpose of defining the term "newly discovered oil," the Tax Reform Act of 1986 clarifies the "exploratory well" exception described in the Conference Committee Report accompanying the Crude Oil Windfall Profit Tax Act of 1980. The 1986 Act provides that the term "newly discovered oil" includes production from a property that produced crude oil in calendar year 1978 if (1) not more than 2,200 barrels was produced from the property in that year, and (2) no well on the property was in production for more than 72 hours during that year. For the purpose of this test, it is irrelevant whether or not the 1978 crude oil production was sold or exchanged, or was retained for beneficial economic use. Also, for the purpose of the second requirement of this test, a dual completion well is treated as two separate wells (*i.e.*, one well for each horizon). The final regulations incorporate this test.

New Lease

The proposed regulations provided that crude oil produced from a new lease on the Outer Continental Shelf would qualify as newly discovered oil. The term "new lease" was defined as a lease entered into on or after January 1, 1979, of submerged acreage that did not produce crude oil in commercial quantities in calendar year 1978. Consequently, the proposed regulations provided that a lease would be denied new lease status if any portion of its submerged acreage was included at any time during 1978 in a lease on the Outer Continental Shelf whose submerged acreage produced crude oil in commercial quantities in calendar year 1978. Some commentators urged that the final regulations should adopt the on-shore property rules and define the term "newly discovered oil" to include crude oil produced from new reservoirs on Outer Continental Shelf leases entered into before 1979.

The final regulations adopt the Outer Continental Shelf rules as proposed in the notice. Section 4991 (e) (2) provides that the term "newly discovered oil" has the meaning given to such term by the June 1979 energy regulations. Under the June 1979 energy regulations, the determination of whether or not Outer Continental Shelf production is treated as newly discovered oil is based entirely on the new lease concept. Unlike the commercial quantities rule, the committee reports did not indicate an intention to depart from the June 1979 energy regulations. Indeed, all references in the legislative history to Outer Continental Shelf production assume that the definition of newly discovered oil provided in the June 1979 energy regulations would remain unchanged in that regard. Consequently, the final regulations provide that newly discovered oil produced from the Outer Continental Shelf is classified only on a lease basis.

Special Analyses

The Commissioner of Internal Revenue has determined that a Regulatory Impact Analysis is not required because this final rule is not a major rule under Executive Order 12291.

The Commissioner of Internal Revenue has concluded that this final regulation is interpretative and that the notice and public procedure requirements of 5 U.S.C. 553 do not apply. Accordingly, this final regulation is a regulation not subject to the Regulatory Flexibility Act (5 U.S.C. chapter 6).

Drafting Information

The principal author of these final regulations was Robert H. Ginsburgh of the Legislation and Regulations Division of the Office of Chief Counsel, Internal Revenue Service. However, personnel from other offices of the Internal Revenue Service and Treasury Department participated in developing these final regulations, both on matters of substance and style.

List of Subjects in 26 CFR Part 51

Excise tax, Petroleum, Crude Oil Windfall Profit Tax Act of 1980.

Adoption of Amendments to the Regulations

The amendments to 26 CFR Part 51 are hereby adopted as set forth below:

PART 51—[AMENDED]

Paragraph 1. The authority citation for Part 51 continues to read in part:

Authority: 26 U.S.C. 4997, 7805. * * *

Par. 2. Section 51.4996–1 is amended by redesignating paragraph (m) as paragraph (o) and by inserting immediately after paragraph (l) new paragraphs (m) and (n), to read as follows:

§ 51.4996–1 Definitions.

* * * * *

(m) *Newly discovered oil*—(1) *In general.* The term "newly discovered oil" means taxable crude oil that either is produced from a newly discovered crude oil property or is imputed newly discovered oil from a unitized property.

(2) *Newly discovered crude oil property.* The term "newly discovered crude oil property" means—

(i) A new lease on the Outer Continental Shelf; or

(ii) A property (not on the Outer Continental Shelf) that did not produce crude oil in commercial quantities in calendar year 1978; or

(iii) Any unitized property that is made up entirely of leases described in paragraph (m)(2)(i) of this section or properties described in paragraph (m)(2)(ii) of this section, or both.

(3) *Imputed newly discovered oil.* [Reserved]

(4) *New lease.* The term "new lease" means any lease of submerged acreage that satisfies all of the following three requirements:

(i) It was entered into on or after January 1, 1979;

(ii) Its submerged acreage did not produce crude oil in commercial quantities in calendar year 1978; and

(iii) No portion of its submerged acreage was included at any time during 1978 in a lease on the Outer Continental Shelf whose submerged acreage produced crude oil in commercial quantities in calendar year 1978. Determinations under paragraph (m)(4)(i) of this section of the date on which a lease was entered into shall be made without regard to any extension, renewal, modification, assignment, or sublease of the lease. Accordingly, the original date on which that lease was

entered into is controlling for purposes of that paragraph.

(5) *Outer Continental Shelf.* The term "Outer Continental Shelf" means Outer Continental Shelf as defined by section 2(a) of the Outer Continental Shelf Lands Act (43 U.S.C. 1331(a)).

(6) *Production in commercial quantities in 1978.* A property (or submerged acreage on the Outer Continental Shelf) produced crude oil in commercial quantities in calendar year 1978 if any crude oil that was produced in calendar year 1978 (other than crude oil production that is disregarded under paragraph (n) of this section because it was incidental to the drilling of an exploratory well, including a test well, and was not part of continuous or commercial production) from that property (or submerged acreage) ultimately was sold or exchanged or was retained for beneficial economic use. However, a property (or submerged acreage) shall be treated as not producing crude oil in commercial quantities in calendar year 1978 if, during calendar year 1978, both of the following requirements are met:

(i) The aggregate amount of crude oil produced from the property (or submerged acreage) did not exceed 2,200 barrels, and

(ii) No well on the property (or submerged acreage) was in production for a total of more than 72 hours.

For the purposes of paragraph (m)(6) (i) and (ii) of this section, it is irrelevant whether or not the crude oil produced was sold or exchanged or was retained for beneficial economic use. In additon, for the purpose of paragraph (m)(6)(ii) of this section, a dual completion well shall be treated as two separate wells (*i.e.*, one well for each horizon).

(n) *Commercial quantities.* Crude oil is produced in commercial quantities if any of the crude oil produced is—

(1) Sold or exchanged; or

(2) Retained for beneficial economic use (*e.g.*, to power any production equipment or to inject into a well).

However, crude oil production that is incidental to the drilling of an exploratory well (including a test well), and that is not part of continuous or commercial production, shall be disregarded. Whether crude oil production is incidental to such drilling and is not part of continuous or commerical production shall be determined on the basis of all the facts and circumstances of the particular case.

(o) *Other.* * * *

Par. 3. Paragraph (b) of § 51.4991–1 is amended by revising the sixth sentence to read as follows:

§ 51.4991–1 Taxable crude oil; tiers of oil.

* * * * *

(b) *Tiers of oil.* * * * The term "newly discovered oil" has the meaning given to that term in § 51.4996–1(m). * * *

Par. 4. Section 51.4988–2 is amended by adding at the end of paragraph (b)(3)(iii) a sixth sentence to read as follows:

§ 51.4988–2 Net income limitation on windfall profit.

* * * * *

(b) *Calculation of net income limitation.* * * *

(3) *Taxable income from the property reduced by cost depletion.*

* * * * *

(iii) * * * See paragraph (n) of § 51.4996–1 for the definition of the term "commercial quantities."

* * * * *

Lawrence B. Gibbs,

Commissioner of Internal Revenue.

Approved: February 12, 1988.

O. Donaldson Chapoton,

Assistant Secretary of the Treasury.

[FR Doc. 88–4484 Filed 3–1–88; 8:45 am]

BILLING CODE 4830–01–M

DEPARTMENT OF LABOR

Occupational Safety and Health Administration

29 CFR Part 1910

Occupational Exposure to Formaldehyde; Approval of Information Collection Requirements; Technical Amendment

AGENCY: Occupational Safety and Health Administration (OSHA), Labor.

ACTION: Notice of partial approval of information collection requirements.

SUMMARY: On December 4, 1987, the Occupational Safety and Health Administration (OSHA) published a final rule in the **Federal Register** for occupational exposure to formaldehyde (29 CFR 1910.1048, 52 FR 46168). This rule was transmitted to the Office of Management and Budget (OMB) for review and clearance of the information collection requirements contained in the final rule, in accordance with the Paperwork Reduction Act of 1980, 44 U.S.C. 3501 *et seq.* and 5 CFR Part 1320. The following information collection requirements contained in the final rule for formaldehyde have now received OMB paperwork clearance: paragraphs (d)(1)(i), (d)(2), (d)(3), (d)(4), (d)(6), (g)(3)(i), (g)(3)(ii), (l)(3), (l)(4), (l)(5), (l)(6), (l)(7), (m)(1), (n)(3), (n)(4), and (o). The OMB clearance number is 1218–0145. The OMB clearance expires on February 28, 1991.

The hazard communication requirements of the Formaldehyde Standard, including labeling and material safety data sheets, paragraphs (m)(1)(i) through (m)(4)(ii), have been disapproved by OMB. Until OSHA determines what further steps to take in response to OMB's denial, OSHA will continue to enforce the labeling and material safety data sheet requirements of the Hazard Communication Standard, 29 CFR 1910.1200, for formaldehyde. This is consistent with OMB's direction to the Agency and with OSHA's application of the Hazard Communication Standard.

EFFECTIVE DATE: March 2, 1988.

FOR FURTHER INFORMATION CONTACT: Mr. James Foster, Occupational Safety and Health Administration, Office of Information and Consumer Affairs, Occupational Safety and Health Administration, U.S. Department of Labor, Room N–3649, 200 Constitution Avenue, NW., Washington, DC 20210. Telephone (202) 523–8151.

SUPPLEMENTARY INFORMATION: OSHA published a final rule on formaldehyde on December 4, 1987 (52 FR 46168). At the time of promulgation of the final rule, the information collection provisions in the standard had not been approved by OMB under the Paperwork Reduction Act. On February 2, 1988, OMB approved all of the information collection requirements of 29 CFR 1910.1048 with the exception of those contained in paragraphs (m)(1)(i), (m)(2), (m)(3), and (m)(4). The clearance control number is 1218–1045. Accordingly, all paragraphs in the standard except paragraphs (m)(1)(i) through (m)(4)(ii) are in effect.

In addition, the Agency inadvertently failed to give a delayed start-up date for updating the written materials in the training program. Therefore, paragraph (p) will be amended to provide sufficient time to allow employers to come into compliance with these requirements.

Authority and Signature

This document was prepared under the direction of John A. Pendergrass, Assistant Secretary of Labor for Occupational Safety and Health, 200 Constitution Avenue NW., Washington, DC 20210.

This action is taken pursuant to sections 4(b), 6(b), and 8(c) of the Occupational Safety and Health Act of 1970 (84 Stat. 1593, 1597, 1599, 29 U.S.C. 653, 655, 657), Secretary of Labor's Order No. 9–83 (48 FR 35736) and 29 CFR Part 1911).

List of Subjects in 29 CFR Part 1910

Formaldehyde, Occupational safety and health, Chemicals, Cancer, Health, Risk assessment.

Signed at Washington, DC, this 26th day of February 1988.

John A. Pendergrass,

Assistant Secretary of Labor.

Part 1910 of Title 29 the Code of Federal Regulations is amended as set forth below:

PART 1910—[AMENDED]

1. The authority citation for Subpart Z of Part 1910 continues to read as follows:

Authority: Secs. 6, 8 Occupational Safety and Health Act, 29 U.S.C. 655, 657; Secretary of Labor's Orders 12–71 [36 FR 8754], 8–76 [41 FR 25059], or 9–83 [48 FR 35736] as applicable; and 29 CFR Part 1911. Section 1910.1000 Tables Z–1, Z–2, Z–3 also issued under 5 U.S.C. 533. * * * Section 1910.048 also issued under 29 U.S.C. 653.

* * * * *

2. By adding a new paragraph (p)(2)(vi) to § 1910.1048 to read as follows:

§ 1910.1048 Formaldehyde.

* * * * *

(p) * * *

(2) * * *

(vi) *Employee training.* Written materials for employee training shall be updated as soon as possible, but no later than two months after the effective date of the standard.

3. By adding the following language at the end of § 1910.1048 to read as follows:

[Approved, except for paragraphs (m)(1)(i) through (m)(4)(ii), by the Office of Management and Budget under Control Number 1218–0145]

[FR Doc. 88–4489 Filed 3–1–88; 8:45 am]

BILLING CODE 4510–26–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 405, 406, 409, 410, 413, 416, 421, 424, 489, and 498

[BERC–431–FC]

Medicare Program; Conditions for Medicare Payment

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule with comment period.

SUMMARY: These rules are part of our ongoing project to assign a separate part of this chapter for each major aspect of the Medicare program. They also—

- Modify the requirements that a home health agency (HHA) must meet to be classified as a "sole community HHA".
- Clarify and simplify previous regulations (without substantive change) so that they are easier to understand and apply.
- Incorporate procedural changes that were put into effect to reduce paperwork and permit more efficient processing of Medicare claims.

DATES: *Effective date:* These regulations are effective March 31, 1988.

Comment date: We will consider comments received by May 2, 1988, from anyone who considers that, in the process of redesignation and clarification, we have made substantive changes other than the procedural changes discussed in this preamble.

ADDRESS: Mail comments to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: BERC–431–FC, P.O. Box 26676, Baltimore, Maryland 21207.

If you comment on information collection requirements, please send a copy of those comments directly to:

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 3208, New Executive Office Building, Washington, DC 20503.

If you prefer, you may deliver your comments to one of the following addresses:

Room 309–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC, or

Room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland.

In commenting, please refer to file code [BERC–431–FC]. Comments received timely will be available for public inspection as they are received, generally beginning approximately three weeks after publication of a document, in Room 309–G of the Department's offices at 200 Independence Avenue SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5:00 p.m. (phone: 202–245–7890).

FOR FURTHER INFORMATION CONTACT: Luisa V. Iglesias, Telephone (202) 245–0383.

SUPPLEMENTARY INFORMATION:

Purpose and Scope

Requirements for Sole Community HHA

Final rules published on June 30, 1986 (51 FR 23541) modified the provisions that prohibit a physician from certifying a need for home health services and establishing a plan for those services if the physician has a "significant interest in, or a significant financial or contractual relationship with" the HHA that would furnish the services.

Those rules also established criteria and procedures to implement one of the provisions of section 2336 of the Deficit Reduction Act of 1984 (Pub. L. 98–369). Under that provision, the above noted prohibition does not apply to "an HHA that is a sole community HHA as determined by the Secretary".

The June 30 rules required, as the condition for an HHA to be classified as a "sole community HHA", that the facility designate a particular area and show that—

- No other HHA provides services within that area; and
- There are no physicians (other than those with a significant interest in, or relationship with the HHA) available to perform certification and plan of treatment functions.

Because we believed that it was in the public interest to put into effect promptly the exemption of sole community HHAs, we included those provisions in the final rule and specifically requested comments on them from the public.

We received comments from two national home health associations, both objecting to the requirement that there be no physicians available (other than those subject to the prohibition) to perform certification and plan of treatment functions. Both groups cited committee reports issued before the Conference Committee Report as stating the intent of Congress to ensure that patients in underserved areas were not forced to change physicians in order to avail themselves of the home health benefit.

After reviewing the legislative history of this amendment, including the committee reports that preceded the Conference Committee Report (S. Rep. No. 98–300, 98th Cong., 1st Sess. 151–52 (1983) and H.R. Rep. No. 98–432, 98th Cong., 1st Sess. 454 (1984)), we agree that the second requirement is contrary to congressional intent. The requirement that there be no other physicians (other than those subject to the prohibition) could indeed nullify that intent by making it necessary for beneficiaries to change doctors in order to be certified in need of home health services and have a plan developed for those services. Accordingly, we are revising redesignated § 424.22(g) to remove paragraph (g)(2).

Procedural Changes

We have revised the regulations to reflect procedural changes already in

effect that extend the validity of request for payment statements to cover more than one Medicare claim, and establish uniform time limits for filing those claims. Claims for payment may be submitted either by the entity that furnished the services or, in some cases, by the beneficiary who received them. But a request for payment, signed by or on behalf of the beneficiary, is required for all claims.

Redesignation and Clarification

These regulations bring together in a new Part 424, policies previously contained in Subparts A and P of Part 405 of the Medicare rules. The new Part 424 will be easier to understand and apply because it uses shorter sentences, lists and numbers separate provisions, and groups related sections under appropriate subparts. For example, it brings together, under a new Subpart G, all the rules pertaining to emergency services furnished by nonparticipating hospitals. Other major topics presented as separate subparts are certification and plan of treatment requirements, claims for payment, special rules that apply to services furnished in a foreign country, and the persons or entities to whom payment may be made.

The redesignation table will help the reader to determine where the content of previous provisions is located in the new Part 424, or in Part 405, 406, or 409.

We note that on July 1, 1986 (51 FR 23792), we published a notice of proposed rulemaking to amend the Medicare regulations to incorporate legislative changes on payment procedures for Medicare Part B benefits. The proposed amendments affect § 405.1685, with conforming changes to §§ 405.1672, 405.1679, and 405.1686. These sections are redesignated in this document as they now exist in the Code of Federal Regulations. When the final regulations are issued on the July 1, 1986 NPRM, the legislative changes will be incorporated in the appropriate sections of the regulations as redesignated.

Provisions of the Regulations

The content of each subpart of the new Part 424, any changes made in those subparts, and the reasons for the changes, are discussed below.

General Provisions

Subpart A—

- Describes the statutory basis and scope of Part 424;
- Summarizes general requirements applicable to all Medicare payments such as the requirement that the services must be covered and the individual must be entitled to Medicare at the time the services are furnished; and
- Sets forth some general limitations that are related to the requirements for utilization review.

Certification Requirements

Subpart B redesignates current requirements for a physician to certify and recertify the need for services, and to establish a plan of treatment and review it periodically. It contains the change discussed above in the requirements for classification as a sole community HHA.

Claims for Payment

Subpart C sets forth the requirements and procedures for Medicare claims and the time limits for a provider or supplier or a beneficiary to file or complete a claim for Medicare payment.

Claims Process

Regardless of who files a claim, the claim must include (or refer to) a request for payment statement signed by or on behalf of the beneficiary. Under previous regulations, the signature of the beneficiary or the beneficiary's representative was normally required on a request for payment statement on each claim submitted. In lieu of obtaining signatures on each claim, providers and physicians and other suppliers could, in certain cases, obtain a separate request for payment statement from the beneficiary, authorizing the submission and processing of claims over an extended period of time. In order to simplify and facilitate the submission and processing of claims, HCFA issued guidelines (sections 3047.1–3047.3 of the carrier manual and section 3302.2 of the intermediary manual) to add other circumstances under which a single request for payment statement (hereafter called "request") may be used. These guidelines are incorporated in § 424.40 of the revised regulations.

They provide that:

1. A hospital or other provider may—

a. When a beneficiary is admitted, obtain a request, effective for the period of confinement, authorizing the provider or any physician to submit claims on the beneficiary's behalf for inpatient services furnished by or in the provider; and

b. At the start of outpatient care, obtain a request that constitutes a lifetime authorization for the provider or any physician to submit claims on the beneficiary's behalf for outpatient services furnished by or in the provider.

In the case of physician services, the claims submitted under an extended request may be either assigned or unassigned.

2. A physician or other supplier may obtain from the beneficiary a request that constitutes a lifetime authorization for the supplier to submit assigned and unassigned claims on the beneficiary's behalf.

Rental of durable medical equipment for which the claim has not been assigned to the supplier is excluded from this provision. This is necessary so that, through a new request, the carrier can learn when the beneficiary has returned the equipment, has recovered, has died, or has gone into an institution. If a claim has been assigned to the supplier, this exclusion is not necessary because the supplier must assume liability for any overpayment that results from its failure to promptly notify the carrier that one of those events has occurred. As a safeguard against program abuse, a supplier is required to obtain a new request whenever a new item of equipment is purchased or rented, regardless of whether the claim is assigned or unassigned.

Under the previous regulations (§ 405.1664(e)), if a provider furnished services without personal contact with the beneficiary (e.g., a hospital did diagnostic tests on a blood sample drawn by the physician in his office and sent to the hospital), the provider could sign the request for payment statement on behalf of the beneficiary. The revised regulation makes this procedure available to suppliers under similar circumstances (e.g., to an independent laboratory that performs tests on a blood sample drawn by the physician at his office and sent to the laboratory). This procedure would not be available to a supplier, however, when the supplier furnishes the services in a facility that has personal contact with the beneficiary. In that situation, the facility can obtain the necessary request covering the supplier's services.

Time Limits

The basic time limits for filing claims (which remain unchanged) are—

- December 31 of the following year for services that were furnished during the first 9 months of a calendar year.
- December 31 of the second following year for services furnished during the last 3 months of a calendar year.

When delay in filing is the result of error or misrepresentation by an employee or agent of the Department, the basic time limit is extended to 6 months after the error or misrepresentation is corrected. Previous regulations (§ 405.1667(b)(1)) limited that extension to December 31 of the third year after the calendar year in which the

services were furnished, but only for services of providers. Section 405.1693 imposed no such additional limit for services payable on a charge basis. The revised regulations (§ 424.35) delete the additional limitation. The aim is to ensure equity when the delay is the result of Department error and to simplify administration by providing a single rule on extension of time limits for filing claims.

Under previous regulations (§ 405.1693), for services payable on a charge basis, a claimant could meet the requirement for timely filing by filing a claim in proper form or a statement of written intent to claim benefits with any intermediary or carrier or HCFA or SSA. (A statement of written intent had to be perfected by filing a claim in proper form by the close of the sixth month after the month in which the carrier advised the claimant to do so.) On the other hand, (under § 405.1667), for services of providers, a claimant would ordinarily meet the requirements for timely filing only by filing the claim in proper form with the appropriate intermediary. (The only exception to this rule was that a provider could establish a filing date for a claim by filing an admission or start-of-care notice with its intermediary and perfecting that notice by the filing of the claim in proper form within 60 days after the intermediary replied to the admission notice.) For the sake of equity and greater uniformity of administration, the revised regulations generally conform the rules on claims for services of providers to those for services payable on a charge basis.

Thus, § 424.45 provides for the use of written statements of intent to claim benefits, and allows 6 months for formalizing a claim, regardless of whether the services are paid to a provider or on a charge basis.

To Whom Payment May be Made

Subparts D and E specify to whom Medicare payment is ordinarily made and to whom Medicare payment is made in special situations.

Section 424.62 deals with Medicare payment after a beneficiary's death, on the beneficiary's claim for direct payment, when the bill has been paid. Section 424.64 deals with situations in which the beneficiary has died and the bill has not been paid.

Limitation on Assignment or Reassignment of Claims

Subpart F redesignates previous regulations that limit assignment and reassigment of claims.

Section 424.73 deals with the limitations on assignment of claims by a provider.

Section 424.74 specifies that HCFA may terminate the provider agreement of a provider that persists in trying to have payment made contrary to the provisions of these regulations.

Section 424.80 deals with the limitations on reassignment of claims by physicians and other suppliers. The basic rule (established by section 1842(b)(6) of the Act) is that Medicare Part B payments may be made only to the beneficiary or to the physician or other supplier that furnished the service. That rule is set forth in paragraph (a); certain exceptions to the rule are specified in paragraph (b).

Sections 424.82 through 424.84 set forth the procedures for revoking a supplier's right to receive assignment if the supplier violates the conditions of assignment, seeks to obtain payment contrary to the regulations, or fails to furnish evidence of compliance with the requirements of 424.80. Section 424.86 deals with the limitations on assignment of claims by individuals.

Section 424.90 deals with court ordered assignments.

Services Furnished by Nonparticipating Hospitals

Subpart G sets forth the special conditions for payment for emergency inpatient or outpatient services furnished to Medicare beneficiaries by a nonparticipating U.S. hospital, that is, a hospital that does not have an agreement (known as a provider agreement) to participate in the Medicare program, but, at the time of the emergency, was nearer or more accessible to the beneficiary than the nearest participating hospital, and was equipped to furnish those services.

Subpart H sets forth the conditions for payment for

- Emergency or nonemergency inpatient services furnished to Medicare beneficiaries by a foreign hospital that was nearer or more accessible (to the site of the emergency or to the patient's residence) than the nearest U.S. hospital; and
- Physicians' services and ambulance services furnished in connection with those inpatient services.

The regulations in these two subparts set forth the conditions the nonparticipating or foreign hospital must meet. They also specify criteria and procedures for determining—

- Whether an emergency existed and when it ended;
- Whether the nonparticipating U.S. hospital was closer or more accessible than the nearest participating hospital; and
- Whether the foreign hospital was closer or more accessible than the nearest U.S. hospital.

Replacement of Medicare Checks

Subpart M sets forth the procedures for replacement of Medicare checks that are lost, stolen, defaced, mutilated, destroyed, or paid on forged endorsement.

Conforming Amendments

Current rules in Part 409 do not set forth the conditions for Medicare Part A payment of emergency services furnished by a nonparticipating hospital in the United States, and of services furnished in Mexico or Canada. Current § 410.168 does specify the conditions for payment of emergency services furnished by nonparticipating U.S. hospitals. In order to avoid duplication but ensure awareness of the conditions set forth for Part A and Part B services in Subparts G and H of the new Part 424, § 410.168 is removed, and reference to Part 424 is added in §§ 409.100 and 410.64. In § 410.175, content that is now covered in §§ 424.5 and 424.32 is removed.

Section 489.30 of the Medicare rules, as amended by final regulations published on November 14, 1986 (51 FR 41350) contained an exception applicable only under Medicare Part B (paragraph (b)(5)). We have now determined that section 1889(b) of the Act, on which the exception is based, also applies under Medicare Part A. Accordingly, we have made a conforming change in § 489.30(a)(4).

Technical Amendments

The redesignation of Subparts A and P of Part 405 required correction of references to those parts, since they are being removed from the CFR. Those corrections include changes in—

- Part 410, which was established by the final rules published on November 14, 1986, and does not yet appear in the printed CFR; and
- Other parts of this chapter with references that were corrected by the November 14 rules, but become outdated with the establishment of Part 424.

Waiver of Proposed Rulemaking

The "Sole Community HHA" change is responsive to public comments, conforms the rule to Congressional intent, and ensures that beneficiaries in rural areas will not have to change physicians in order to receive home health services.

The changes discussed under "Procedural Changes" reduce

administrative burdens and restrictions and contribute to more equitable and efficient handling of Medicare claims. The remaining sections of the regulation represent a reorganization and rewriting of current policy with no substantive change. Accordingly, we find that there is good cause to dispense with proposed rulemaking.

However, as previously indicated, we will consider comments from anyone who believes that, in the process of reorganizing and simplifying the existing regulations, we inadvertently have made substantive changes. We will modify the redesignated regulations if comments indicate that this is necessary. Although we cannot acknowledge individual comments, if we change these regulations, we will discuss the comments in the preamble to the revised regulations.

Regulatory Impact Statement

Executive Order 12291

Executive Order 12291 requires us to prepare and publish a regulatory impact analysis for any regulation that is likely to have an annual economic impact of $100 million or more, cause a major increase in costs or prices, or meet other thresholds specified in section 1(b) of the order.

We have determined that a regulatory impact analysis is not required for these rules because they will not have an annual impact of $100 million or more or meet any of the other criteria.

Regulatory Flexibility Act (RFA)

Consistent with the RFA, we prepare and publish a regulatory flexibility analysis for any regulation that will have "a significant economic impact on a substantial number of small entities". A small entity is defined as a small business, a nonprofit enterprise, or a governmental jurisdiction (such as a county, city, or township) with a population of less than 50,000. We consider all providers and suppliers as small entities.

We have determined, and the Secretary certifies, that, as shown by the discussion under "waiver of proposed rulemaking", these rules will not have a significant economic impact on a substantial number of small entities.

Paperwork Reduction Act

These regulations contain no new information collection requirements subject to review by the Office of Management and Budget under the Paperwork Reduction Act of 1980.

List of Subjects

42 CFR Part 405

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Nursing home, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 406

Health facilities, Kidney diseases, Medicare.

42 CFR Part 409

Health facilities, Medicare.

42 CFR Part 410

Medical and other health services, Medicare.

42 CFR Part 424

Assignment of benefits, Physician certification, Claims for payment, Emergency services, Plan of treatment.

Redesignation Table

Old section	New section
405.100	424.10.
405.150	409.100 and 424.51.
405.152(a) (1) and (2)	424.101.
405.152(a)(3)	424.103 Introductory text.
405.152(a)(4)	Removed as duplicative of 405.152(c).
405.152(a)(5)	424.103(a)(2).
405.152(a)(6)	Removed as duplicative of 405.1660.
405.152(a)(7)	424.103(a)(1).
405.152(a)(8)	424.103(b).
405.152(b)	424.101.
405.152 (c), (d), and (e)	424.104.
405.153(a)	424.121(a).
405.153(a)(1)	424.122(a).
405.153(a)(2)	424.122(b).
405.153(a)(3)	424.122(d) and 424.123 (c) and (d).
405.153(b)	424.121(a).
405.153(b)(1)	424.123(a).
405.153(b)(2)	424.123(b).
405.153(b)(3)	424.123(c).
405.153(c)(1)	424.123(d) and 424.126.
405.153(c)(2)	424.127.
405.157	424.103(a) and 424.109(a).
405.158	424.109(b).
405.160(a) (1) and (2)	424.5.
405.160(a)(3)	424.7.
405.160(b)(1)	424.5(a)(5).
405.160(b)(2)	424.5(a)(4), 424.11, 424.14.
405.160(b)(3)	424.14.
405.160(b)(4)	424.7.
405.160(c)	Removed as no longer pertinent. Inpatient services in TB hospitals are no longer included in the statute.
405.162	424.7(a).
405.163	424.7(b).
405.165(a)	424.5(a)(5).
405.165(b)	424.5(a)(4), 424.11, 424.20.
405.165(c)	424.7.
405.166	424.7(a).
405.167	424.7(b).
405.170(a)	424.5(a)(5).
405.170(b)	424.5(a)(4), 424.11, 424.22.
405.170(c)	424.5(a)(1).
405.191(a)	424.103(a)(4).
405.191(b)	Removed as unnecessary.
405.191(b)(1)	424.103(b).
405.191(b)(2)	424.103(b).
405.191(b)(3)	424.103(a)(3).
405.191(b)(4) 1st sentence.	Removed as poor example.
405.191(b)(4) 2nd sentence.	424.102(a).
405.191(b)(5)	424.102(b).
405.192(a)	424.106(a).
405.192(b)	Removed as unnecessary.
405.192(b) (1)–(3)	424.106(b).
405.192(b)(4)	424.106(c).
405.192(c)	424.106(d).
405.192(d)(1)	Removed as inconsistent with definition of emergency.
405.192(d)(2)	Removed as redundant with 405.192(c).
405.1625(a)	424.10(a).
405.1625(b)	424.11(a).
405.1625(c)	424.11(b).
405.1625(d)	424.11(c).
405.1625(e)	424.11(d).
405.1627 (a)(1)–(a)(3)	424.13(a).
405.1627(b)	424.13(b).
405.1627(c)	424.13(c).
405.1627(d)	424.13(d).
405.1627(e)(1)	424.13(d).
405.1627(e)(2)	424.13(e).
405.1627(e)(3)	424.13(f).
405.1627(e)(4)	424.13(g).
405.1629 Undesignated portion.	424.14 (a) and (d).
405.1629 (a) and (b)	424.14 (b) and (c).
405.1629(c)	Removed as no longer pertinent. (See comment on § 405.160(c)).
405.1630	424.16.
405.1632(a)	424.20, Introductory statement.
405.1632(b)	424.20(a).
405.1632(c)	424.20(b).
405.1632(d)	424.20(c).
405.1632(e) (1) and (2)	424.20(d).
405.1632(e)(3)	424.20(f).
405.1632(e)(4)	424.20(g).
405.1632(f)	424.20(e).
405.1633	424.22.
405.1634(a)(1)	424.24(a).
405.1634(a)(2)	424.24(c)(4).
405.1634(a)(3)	Removed as duplicative of 405.1625(c).
405.1634(a)(4)	424.24(c)(3).
405.1634(a)(5)	424.24(c)(2).
405.1634(b)	424.24(c)(1) and 424.25.
405.1634(c)	424.24(d).
405.1635	424.27.
405.1660 (a) and (b)	Removed as duplicative of other content.
405.1660(c)	424.5(a)(5).
405.1662(a) 1st sentence.	405.207 and 406.7.
405.1662(a) 2nd and 3rd sentences.	424.32(a).
405.1662(a) last sentence.	Removed as unnecessary.
405.1662(b) list of forms	405.207 and 406.7.
405.1662(b) narrative	Removed as duplicative of 405.205 and 406.6.
405.1662(c)	424.32(b).
405.1662(d)	405.207, 406.7, and 424.32(c).

Old section	New section
405.1663 Undesignated portion.	424.5(a)(5).
405.1663 (a) and (c)	424.40(b)(1).
405.1663 (b) and (d)	424.40(b)(2).
405.1664	424.36 and 424.37(b).
405.1665	424.37(a).
405.1666	424.36.
405.1667(a)	424.32.
405.1667(b) (1) and (2)	424.44.
405.1667(b)(3)	424.45.
405.1667(c)	Removed as outdated.
405.1668(a)	424.70.
405.1668 (b) and (c)	424.73.
405.1668(d)	424.74.
405.1672 (a) and (b)	424.53.
405.1672(c)	424.34(a).
405.1672(d)	424.54.
405.1672 (e) and (f)	424.73(b), 424.80(b), 424.86(b).
405.1674	424.34.
405.1675(a)(1)	424.55.
405.1675(a)(2)	424.56.
405.1675(b)	424.80(c).
405.1678	Removed as duplicative of 405.1675.
405.1679	424.36.
405.1680(a)	424.70(b).
405.1680(b)	424.71.
405.1680(c)	424.80(a).
405.1680(d)	424.80(b).
405.1681 (a)-(h)	424.82.
405.1681 (i) and (j)	424.83.
405.1681 (k) and (l)	424.84.
405.1682(a)	424.71.
405.1682(b)	424.90(a).
405.1682(c)	424.90(b).
405.1682(d)	424.90(c).
405.1683	424.62.
405.1684	424.64.
405.1685	424.66 (c) and (d).
405.1686	424.66(a).
405.1692	424.44.
405.1693	424.45.
405.1694	424.44(c).
405.1695	424.350.
405.1696	424.352.
405.1697	424.354.

42 CFR Chapter IV is amended as set forth below:

A.

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

Part 405 is amended as follows:

Subpart A—[Removed and Reserved]

1. Subpart A (§§ 405.100–405.192) is removed and reserved, and the table of contents is amended to reflect this change.

2. Subpart B is amended as set forth below:

a. The Subpart heading is revised to read:

Subpart B—Supplementary Medical Insurance Enrollment and Entitlement

b The authority citation for Subpart B is revised to read:

Authority: Secs. 1102, 1836–1838, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395o–1395q, and 1395hh) unless otherwise noted.

c. A new § 405.207 is added, to read as set forth below, and the table of contents is amended to reflect that addition:

§ 405.207 Forms used to apply for enrollment under Medicare Part B.

The following forms, available free of charge by mail from HCFA, or at any Social Security branch or district office, are used to apply for enrollment under the supplementary medical insurance program.

HCFA–4040—Application for Enrollment in the Supplementary Medical Insurance Program. (This form is used for enrollment by individuals who are not eligible for monthly benefits or for hospital insurance.)

HCFA–40–B—Application for Medical Insurance. (For general use by the SSA District Office in requesting medical insurance protection during the general enrollment period or during the initial enrollment period if the enrollee is not subject to automatic enrollment is SMI.)

HCFA–40–D—Application for Enrollment in the Suplementary Medical Insurance Program. (This form is mailed to individuals who do not have current supplementary medical insurance because of prior refusals, voluntary withdrawal, or premium default from prior coverage. It is used during the annual general enrollment period.)

HCFA–40–F—Application for Medical Insurance. (For use by beneficiaries residing outside the United States.)

HCFA–18–F–5—Application for Hospital Insurance Entitlement. (For use by individuals who are not eligible for retirement benefits under Title II of the Social Security Act or under the Railroad Retirement Act. This form may also be used for enrollment in the supplementary medical insurance program.)

As an alternative, the individual may request enrollment by answering the Part B enrollment questions on an application for monthly Social Security benefits, or by signing a simple statement of request, if he or she is eligible to enroll at that time.

Subpart P—[Removed and Reserved]

3. Subpart P is removed and reserved, and the table of contents is amended to reflect this change.

B.

PART 406—HOSPITAL INSURANCE ELIGIBILITY AND ENTITLEMENT

The authority citation for Part 406 is revised to read as follows:

Authority: Secs. 202(t), 202(u), 226, 226A, 1102, 1818, and 1871 of the Social Security Act (42 U.S.C. 402(t) 402(u), 426, 426–1, 1302, 1395i–z, and 1395hh) and 3103 of Pub. L. 89–97 (42 U.S.C. 426a) unless otherwised noted.

Part 406 is amended by adding a new § 406.7 to read as set forth below, and amending the table of contents to reflect this addition:

§ 406.7 Forms to apply for entitlement under Medicare Part A.

The following forms, available free of charge by mail from HCFA or at any Social Security branch or district office, are used to apply for Medicare entitlement under the circumstances indicated:

HCFA–18–F–5—Application for Hospital Insurance Entitlement. (For use by individuals who are not eligible for retirement benefits under Title II of the Social Security Act or under the Railroad Retirement Act. This form may also be used for enrollment in the supplementary medical insurance program.)

HCFA–43—Application for Health Insurance Benefits under Medicare for Individuals with End Stage Renal Disease (ESRD). (An initial application for entitlement by individuals with ESRD).

As an alternative, an individual may use the application for monthly social benefits to apply also for Medicare entitlement if he or she is eligible for hospital insurance at that time.

C.

PART 409—HOSPITAL INSURANCE BENEFITS

1. The authority citation for Part 409 continues to read as follows:

Authority: Secs. 1102, 1812, 1813, 1814, 1861, 1866, 1971, 1881, and 1883 of the Social Security Act (42 U.S.C. 1302, 1395d, 1395e, 1395f, 1395x, 1395cc, 1395hh, 1395rr and 1395tt).

§ 409.69 [Removed]

2. Section 409.69 is removed and the table of contents is amended to reflect this change and to add a new Subpart H as follows:

Subpart H—Payment of Hospital Insurance Benefits

Sec.
409.100 To whom payment is made.
409.102 Amounts of payment.

3. A new Subpart H is added to read as follows:

Subpart H—Payment of Hospital Insurance Benefits

§ 409.100 To whom payment is made.

(a) *Basic rule.* Except as provided in paragraph (b) of this section, Medicare pays hospital insurance benefits only to a participating provider.

(b) *Exceptions.* Medicare may pay hospital insurance benefits as follows:

(1) For emergency services furnished by a nonparticipating hospital, to the hospital or to the beneficiary, under the conditions prescribed in Subpart G of Part 424 of this chapter.

(2) For services furnished by a Canadian or Mexican hospital, to the hospital or to the beneficiary, under the conditions prescribed in Subpart H of Part 424 of this chapter.

§ 409.102 Amounts of payment.

(a) The amounts Medicare pays for hospital insurance benefits are generally determined in accordance with Part 412 or Part 413 of this chapter.

(b) Except as provided in §§ 409.61(d) and 409.89, hospital insurance benefits are subject to the deductible and coinsurance requirements set forth in Subpart G of this part.

D.

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

1. The authority citation for Part 410 continues to read:

Authority: Secs. 1102, 1832, 1833, 1835, 1861(r), (s) and (cc), 1871, and 1881 of the Social Security Act (42 U.S.C. 1302, 1395k, 1395l, 1395n, 1395x, (r), (s) and (cc), 1395hh, and 1395rr).

2. Part 410 is amended as set forth below:

a. A new § 410.64 is added, to read as follows and the table of contents is amended to reflect the addition:

§ 410.64 Emergency outpatient services furnished by a nonparticipating hospital and services furnished in Mexico or Canada.

Conditions for payment of emergency outpatient services furnished by a nonparticipating U.S. hospital and for services furnished in Mexico or Canada are set forth in Subparts G and H of Part 424 of this chapter.

§ 410.168 [Removed]

b. Section 410.168 is removed, the table of contents is amended to reflect that change, and all references to "§ 410.168", throughout this Chapter IV, are changed to refer to "Subpart G of Part 424 of this chapter".

c. Section 410.175 is revised to read as follows:

§ 410.175 Alien absent from the United States.

(a) Medicare does not pay Part B benefits for services furnished to an individual who is not a citizen or a national of the United States if those services are furnished in any month for which the individual is not paid monthly social security cash benefits (or would not be paid if he or she were entitled to those benefits) because he or she has been outside the United States continuously for 6 full calendar months.

(b) Payment of benefits resumes with services furnished during the first full calendar month the alien is back in the United States.

E.

Part 424 is added to read as follows:

PART 424—CONDITIONS FOR MEDICARE PAYMENT

Subpart A—General Provisions

Sec.

Subpart B—Physician Certification and Plan of Treatment Requirements

Subpart C—Claims for Payment

Subpart D—To Whom Payment is Ordinarily Made

Subpart E—To Whom Payment is Made in Special Situations

Subpart F—Limitations on Assignment and Reassignment of Claims

Subpart G—Special Conditions: Emergency Services Furnished by a Nonparticipating Hospital

Subpart H—Special Conditions: Services Furnished in a Foreign Country

Subparts I-L—[Reserved]

Subpart M—Replacement and Reclamation of Medicare Payments

Authority: Secs. 216(j), 1102, 1814, 1815(c), 1835, 1842(b), 1861, 1866(d), 1870 (e) and (f), 1871 and 1872 of the Social Security Act (42 U.S.C. 416(j), 1302, 1395f, 1395g, 1395n, 1395u, 1395x, 1395cc, 1395gg, 1395hh and 1395ii).

Subpart A—General Provisions

§ 424.1 Basis and scope.

(a) *Statutory basis.* This part implements the provisions of sections 1814, 1835, 1842(b)(3), and 1870 (e) and (f) of the Act, which establish conditions for and limitations on Medicare payments, and sections 1815(c) and 1842(b)(6), which prohibit assignment or reassignment of the right to those payments.

(b) *Scope.* This part sets forth certain specific conditions and limitations applicable to Medicare payments and cites other conditions and limitations set forth elsewhere in this chapter. This Subpart A provides a general overview. Other subparts deal specifically with—

(1) The requirement that a physician certify the need for services and establish a plan of treatment (Subpart B);

(2) The procedures and time limits for filing claims (Subpart C);

(3) The individuals or entities to whom payment may be made (Subparts D and E);

(4) The limitations on assignment and reassignment of claims (Subpart F);

(5) Special requirements that apply to services furnished by nonparticipating U.S. hospitals and foreign hospitals (Subparts G and H); and

(6) The replacement and reclamation of Medicare payment checks (Subpart M).

Except for § 424.40(c)(3), this part does not deal with the conditions for payment of rural health clinic (RHC) services or ambulatory surgical center (ASC) services. Those conditions are set forth in Part 405, Subpart X, and Part 481 Subpart A of this chapter for RHC services; and in Part 416 of this chapter, for ASC services.

§ 424.3 Definitions.

As used in this part, unless the context indicates otherwise—

"Nonparticipating hospital" means a hospital that does not have in effect a provider agreement to participate in Medicare.

"Participating hospital" means a hospital that has in effect a provider agreement to participate in Medicare.

§ 424.5 Basic conditions.

(a) As a basis for Medicare payment, the following conditions must be met:

(1) *Types of services.* The services must be—

(i) Covered services, as specified in Part 409 or Part 410 of this chapter; or

(ii) Services excluded from coverage as custodial care or services not reasonable and necessary, but reimbursable in accordance with §§ 405.332 through 405.334 of this chapter, pertaining to limitation of liability.

(2) *Sources of services.* The services must have been furnished by a provider, nonparticipating hospital, or supplier that was, at the time it furnished the services, qualified to have payment made for them.

(3) *Recipient of services.* Except as provided in § 409.68 of this chapter, the services must have been furnished while the individual was eligible to have payment made for them. (Section 409.68 provides for payment on inpatient hospital services furnished before the hospital is notified that the beneficiary has exhausted the Medicare benefits available for the current benefit period.)

(4) *Certification of need for services.* When required, the provider must obtain physician certification and recertification of the need for the services in accordance with Subpart B of this part.

(5) *Claim for payment.* The provider, supplier, or beneficiary, as appropriate, must file a claim that includes or makes reference to a request for payment, in accordance with Subpart C of this part.

(6) *Sufficient information.* The provider, supplier, or beneficiary, as appropriate, must furnish to the intermediary or carrier sufficient information to determine whether payment is due and the amount of payment.

(b) Additional conditions applicable in certain circumstances or to certain services are set forth in other sections of this part.

§ 424.7 General limitations.

(a) *Utilization review finding on medical necessity.* When a PRO or a UR committee notifies a hospital or SNF of its finding that further services are not medically necessary, the following rules apply:

(1) *Hospitals subject to PPS.* Payment may not be made for inpatient hospital services furnished by a PPS hospital after the second day after the day on which the hospital received the notice.

(2) *Hospitals not subject to PPS and SNFs.*—(i) *Basic rule.* Except as provided in paragraph (a)(2) of this section, payment may not be made for inpatient hospital services or posthospital SNF care furnished after the day on which the hospital or SNF received the notice.

(ii) *Exception.* Payment may be made for 1 or 2 additional days if the PRO or UR committee approves them as necessary for planning for post-discharge care.

(b) *Failure to make timely utilization review.* Payment may not be made for inpatient hospital services or posthospital SNF care furnished, after the 20th consecutive day of a stay, to an individual who is admitted to the hospital or SNF after HCFA has determined that the hospital or SNF has failed to make timely utilization review in long stay cases. (This provision does not apply to a hospital or SNF for which a PRO has assumed binding review.)

Subpart B—Physician Certification and Plan of Treatment Requirements

§ 424.10 Purpose and scope.

(a) *Purpose.* The physician has a major role in determining utilization of health services furnished by providers. The physician decides upon admissions, orders tests, drugs, and treatments, and determines the length of stay. Accordingly, sections 1814(a)(2) and 1835(a)(2) of the Act establish as a condition for Medicare payment that a physician certify the necessity of the services and, in some instances, recertify the continued need for those services.

(b) *Scope.* This subpart sets forth the content and timing requirements for certification and recertification of need for most services and the plan of treatment requirements for home health services, outpatient physical therapy and speech pathology services, home dialysis support services, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.

§ 424.11 General procedures.

(a) *Responsibility of the provider.* The provider must—

(1) Obtain the required certification and recertification statements;

(2) Keep them on file for verification by the intermediary, if necessary; and

(3) Certify, on the appropriate billing form, that the statements have been obtained and are on file.

(b) *Obtaining the certification and recertification statements.* No specific procedures or forms are required for certification and recertification statements. The provider may adopt any method that permits verification. The certification and recertification statements may be entered on forms, notes, or records that a physician signs, or on a special separate form. Except as provided in paragraph (d) of this section for delayed certifications, there must be

a separate signed statement for each certification or recertification.

(c) *Required information.* The succeeding sections of this subpart set forth specific information required for different types of services. If that information is contained in other provider records, such as physicians' progress notes, it need not be repeated. It will suffice for the statement to indicate where the information is to be found.

(d) *Timeliness.* (1) The succeeding sections of this subpart also specify the time frames for certifications and for initial and subsequent recertifications.

(2) A hospital or SNF may provide for obtaining a certification or recertification earlier than required by these regulations, or vary the time frame (within the prescribed outer limits) for different diagnostic or clinical categories.

(3) Delayed certification and recertification statements are acceptable when there is a legitimate reason for delay. (For instance, the patient was unaware of his or her entitlement when he or she was treated.) Delayed certification and recertification statements must include an explanation of the reason for the delay.

(4) A delayed certification may be included with one or more recertifications on a single signed statement.

(e) *Limitation on authorization to sign statements.* A physician certification or recertification statement may be signed only by one of the following:

(1) A physician who is a doctor of medicine or osteopathy.

(2) A dentist in the circumstances specified in § 424.13(c).

(3) A doctor of podiatric medicine if his or her certification is consistent with—

(i) The policy of the institution or agency to which he or she provides the certification; and

(ii) The functions he or she is authorized to perform under State law.

§ 424.13 Requirements for inpatient services of hospitals other than psychiatric hospitals.

(a) *Content of certification and recertification.* Medicare Part A pays for inpatient hospital services of hospitals other than psychiatric hospitals only if a physician certifies and recertifies the following:

(1) The reasons for either—

(i) Continued hospitalization of the patient for medical treatment or medically required inpatient diagnostic study; or

(ii) Special or unusual services for cost outlier cases (under the prospective payment system set forth in Subpart F of Part 412 of this chapter).

(2) The estimated time the patient will need to remain in the hospital.

(3) The plans for posthospital care, if appropriate.

(b) *Certification of need for hospitalization when a SNF bed is not available.* (1) A physician may certify or recertify need for continued hospitalization if the physician finds that the patient could receive proper treatment in a SNF but no bed is available in a participating SNF.

(2) If this is the basis for the physician's certification or recertification, the required statement must so indicate; and the physician is expected to continue efforts to place the patient in a participating SNF as soon as a bed becomes available.

(c) *Signatures.* (1) *Basic rule.* Except as specified in paragraph (c)(2) of this section, certifications and recertifications must be signed by the physician responsible for the case, or by another physician who has knowledge of the case and who is authorized to do so by the responsible physician or by the hospital's medical staff.

(2) *Exception.* If the intermediary requests certification of the need to admit a patient in connection with dental procedures, because his or her underlying medical condition and clinical status or the severity of the dental procedures require hospitalization, that certification may be signed by the dentist caring for the patient.

(d) *Timing of certifications and recertifications: Cases not subject to the prospective payment system.* (PPS) (1) For cases that are not subject to PPS, certification is required no later than as of the 12th day of hospitalization. A hospital may, at its option, provide for the certification to be made earlier, or it may vary the timing of the certification within the 12-day period by diagnostic or clinical categories. (2) The first recertification is required no later than as of the 18th day of hospitalization. (3) Subsequent recertifications are required at intervals established by the UR committee (on a case-by-case basis if it so chooses), but no less frequently than every 30 days.

(e) *Timing of certification and recertification: Cases subject to PPS.* For cases subject to PPS, certification is required as follows:

(1) For day-outlier cases, certification is required no later than one day after the hospital reasonably assumes that the case meets the outlier criteria, established in accordance with § 412.80(a)(1)(i) of this chapter, or no later than 20 days into the hospital stay, whichever is earlier. The first and subsequent recertifications are required at intervals established by the UR committee (on a case-by-case basis if it so chooses) but not less frequently than every 30 days.

(2) For cost-outlier cases, certification is required no later than the date on which the hospital requests cost outlier payment or 20 days into the hospital stay, whichever is earlier. If possible, certification must be made before the hospital incurs costs for which it will seek cost outlier payment. In cost outlier cases, the first and subsequent recertifications are required at intervals established by the UR committee (on a case-by-case basis if it so chooses).

(f) *Recertification requirement fulfilled by utilization review.* (1) At the hospital's option, extended stay review by its UR committee may take the place of the second and subsequent physician recertifications required for cases not subject to PPS and for PPS day-outlier cases.

(2) A utilization review that is used to fulfill the recertification rquirement is considered timely if performed no later than the seventh day after the day the physician recertification would have been required. The next physician recertification would need to be made no later than the 30th day following such review; if review by the UR committee took the place of this physician recertification, the review could be performed as late as the seventh day following the 30th day.

(g) *Description of procedures.* The hospital must have available on file a written description that specifies the time schedule for certifications and recertifications, and indicates whether utilization review of long-stay cases fulfills the requirement for second and subsequent recertifications of all cases not subject to PPS and of PPS day outlier cases.

§ 424.14 Requirements for inpatient services of psychiatric hospitals.

(a) *Content of certification and recertification: General considerations.* The content requirements differ from those for other hospitals because the care furnished in psychiatric hospitals is often purely custodial and thus not covered under Medicare. The purpose of the statements, therefore, is to help ensure that Medicare pays only for services of the type appropriate for Medicare coverage. Accordingly, Medicare Part A pays for inpatient care in a psychiatric hospital only if a physician certifies and recertifies the need for services consistent with the

content of paragraphs (b) or (c) of this section, as appropriate.

(b) *Content of certification.* Inpatient psychiatric services were required—

(1) For treatment that could reasonably be expected to improve the patient's condition; or

(2) For diagnostic study.

(c) *Content of recertification.* (1) Inpatient services furnished since the previous certification or recertification were, and continue to be, required—

(i) For treatment that could reasonably be expected to improve the patient's condition; or

(ii) For diagnostic study; and

(2) The hospital records show that the services furnished were—

(i) Intensive treatment services;

(ii) Admission and related services necessary for diagnostic study; or

(iii) Equivalent services.

(d) *Timing of certification and recertification.* (1) Certification is required at the time of admission or as soon thereafter as is reasonable and practicable.

(2) The first recertification is required as of the 18th day of hospitalization. Subsequent recertifications are required at intervals established by the UR committee (on a case-by-case basis if it so chooses), but no less frequently than every 30 days.

(e) *Other requirements.* Psychiatric hospitals must also meet the requirements set forth in § 424.13 (b), (c), (f), and (g).

§ 424.16 Timing of certification for individual admitted to a hospital before entitlement to Medicare benefits.

(a) *Basic rule.* If an indivdual is admitted to a hospital before becoming entitled to Medicare benefits (for instance, before attaining age 65), the day of entitlement (instead of the day of admission) is the starting point for the time limits specified in § 424.13(e) for certification and recertification.

(b) *Example. (Hospital other than a psychiatric hospital).* For a patient who is admitted on August 15 and becomes entitled on September 1—

(1) The certification is required no later than September 12;

(2) The first recertification is required no later than September 18; and

(3) Subsequent recertifications are required at least every 30 days after September 18.

§ 424.20 Requirements for posthospital SNF care.

Medicare Part A pays for posthospital SNF care furnished by a SNF or a hospital with a swing-bed approval only if a physician certifies and recertifies the need for services consistent with the content of paragraph (a) or (c) of this section, as appropriate.

(a) *Content of certification.* (1) Posthospital SNF care is or was required because the individual needs or needed on a daily basis skilled nursing care (furnished directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services that, as a practical matter, can only be provided in a SNF or a swing-bed hospital on an inpatient basis; and

(2) The SNF care is or was needed for a condition for which the individual received inpatient care in a participating hospital or a qualified hospital, as defined in § 409.3 of this chapter.

(b) *Timing of certification.* The certification must be obtained at the time of admission or as soon thereafter as is reasonable and practicable.

(c) *Content of recertifications.* (1) The reasons for the continued need for posthospital SNF care;

(2) The estimated time the individual will need to remain in the SNF;

(3) Plans for home care, if any; and

(4) If appropriate, the fact that continued services are needed for a condition that arose after admission to the SNF and while the individual was still under treatment for the condition for which he or she had received inpatient hospital services.

(d) *Timing of recertifications.* (1) The first recertification is required no later than the 14th day of posthospital SNF care.

(2) Subsequent recertifications are required at least every 30 days after the first recertification.

(e) *Signature.* Certification and recertification statements may be signed by the physician responsible for the case or, with his or her authorization, by a physician on the SNF staff or a physician who is available in case of an emergency and has knowledge of the case.

(f) *Recertification requirement fulfilled by utilization review.* A SNF may substitute utilization review of extended stay cases for the second and subsequent recertifications, if it includes this procedure in its utilization review plan.

(g) *Description of procedures.* The SNF must have available on file a written description that specifies the certification and recertification time schedule and indicates whether utilization review is used as an alternative to the second and subsequent recertifications.

§ 424.22 Requirements for home health services.

Medicare Part A or Part B pays for home health services only if a physician certifies and recertifies the content specified in paragraphs (a)(1) and (b)(2) of this section, as appropriate.

(a) *Certification—*

(1) *Content of certification.* As a condition for payment of home health services under Medicare Part A or Medicare Part B, a physician must certify as follows:

(i) The individual needs or needed intermittent skilled nursing care, or physical or speech therapy, or (for the period from July through November 30, 1981) occupational therapy.

(ii) Home health services were required because the individual was confined to the home except when receiving outpatient services.

(iii) A plan for furnishing the services has been established and is periodically reviewed by a physician who is a doctor of medicine, osteopathy, or podiatric medicine, and who is not precluded from performing this function under paragraph (d) of this section. (Performance of plan of treatment functions by a doctor of podiatric medicine is subject to limitations specified in § 409.42(d) of this chapter.)

(iv) The services were furnished while the individual was under the care of a physician who is a doctor of medicine, osteopathy, or podiatric medicine.[1] (Care by a doctor of podiatric medicine fulfills this requirement only if the conditions of § 409.42(b)(2) of this chapter are met.)

(2) *Timing and signature.* The certification of need for home health services must be obtained at the time the plan of treatment is established or as soon thereafter as possible and must be signed by the physician who establishes the plan.

(b) *Recertification*—(1) *Timing and signature of recertification.* Recertification is required at least every 2 months, preferably at the time the plan is reviewed, and must be signed by the physician who reviews the plan.

(2) *Content and basis of recertification.* The recertification statement must indicate the continuing need for services and estimate how much longer the services will be required. Need for occupational therapy may be the basis for continuing services that were initiated because the individual needed skilled nursing care or physical or speech therapy.

(c) *Certification by a doctor of podiatric medicine.* After December 31,

[1] As a condition of Medicare Part A payment for home health services furnished before July 1981, the physician was also required to certify that the services were needed for a condition for which the individual had received inpatient hospital or SNF services.

1980, for purposes of certifying and recertifying need for home health services, the term "physician" may include a doctor of podiatric medicine if—

(1) The beneficiary needs the services because of a podiatric condition which that doctor is legally authorized to treat; and

(2) Performance of the certification function by a doctor of podiatric medicine is consistent with the HHA's policy.

(d) *Limitations on the performance of certification and plan of treatment functions.*—(1) *Basic rule.* Beginning November 26, 1982, and except as provided in paragraph (e) of this section, need for home health services to be provided by an HHA may not be certified or recertified, and a plan of treatment may not be established and reviewed, by any physician who has a significant ownership interest in, or a significant financial or contractual relationship with, that HHA.

(2) *Significant ownership interest.* A physician is considered to have a significant ownership interest in an HHA if he or she—

(i) Has a direct or indirect ownership interest of 5 percent or more in the capital, the stock, or the profits of the home health agency; or

(ii) Has an ownership interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation that is secured by the agency, if that interest equals 5 percent or more of the agency's assets.

(3) *Significant financial or contractual relationship.* Beginning November 26, 1982, a physician is considered to have a significant financial or contractual relationship with an HHA if he or she—

(i) Receives any compensation as an officer or director of the HHA; or

(ii) Has direct or indirect business transactions with the HHA that, in any fiscal year, amount to more than $25,000 or 5 percent of the agency's total operating expenses, whichever is less. Business transactions means contracts, agreements, purchase orders, or leases to obtain services, supplies, equipment, and space and, after August 29, 1986, salaried employment.

(4) *Exemption of uncompensated officer director.* A physician who serves as an uncompensated officer or director of an HHA is not precluded from performing physician certification and plan of treatment functions for that HHA.

(e) *Exceptions to limitations.*—(1) *Exceptions for governmental entities.* The limitations of paragraph (d) of this section do not apply to an HHA that is operated by a Federal, State, or local governmental authority.

(2) *Exception for sole community HHAs.* The limitations of paragraph (d) of this section do not apply on or after the date on which the HHA is classified as a sole community HHA in accordance with paragraphs (f) and (g) of this section.

(f) *Procedures for classification as a sole community HHA.* (1) The HHA must submit to its intermediary a request for classification, showing that it meets the conditions of paragraph (g) of this section.

(2) The intermediary reviews the request and sends the request, with its recommendations, to HCFA.

(3) HCFA reviews the request and the intermediary's recommendation and forwards its approval or disapproval to the intermediary

(4) An approved classification as sole community HHA remains in effect without need for reapproval unless there is a change in the circumstances under which the classification was approved.

(g) *Basis for classification as a sole community HHA.* HCFA approves a classification as sole community HHA only if the HHA designates a particular area and shows that no other HHA provides services within that area.

§ 424.24 Requirements for medical and other health services under Medicare Part B.

(a) *Exempted services.* Certification is not required for—

(1) Hospital services and supplies, including drugs and biologicals that cannot be self-administered, incident to physicians' services furnished to outpatients;

(2) Outpatient hospital diagnostic services, including necessary drugs and biologicals, ordinarily furnished or arranged for by a hospital for the purpose of diagnostic study; or

(3) Outpatient physical therapy services furnished in the patient's home or in the practitioner's office, by or under the direct supervision of a qualified physical therapist in independent practice. (See § 424.25 for plan of treatment requirements applicable to these services.)

(b) *General rule.* Medicare Part B pays for medical and other health services not exempted under paragraph (a) of this section only if a physician certifies the content specified in paragraph (c)(1), (c)(4), (d), or (e)(1) of this section, as appropriate.

(c) *Outpatient physical therapy and speech pathology services.*—(1) *Content of certification.* (i) The individual needs, or needed, physical therapy or speech pathology services.

(ii) The services were furnished while the individual was under the care of a physician. (For physical therapy services furnished after July 17, 1984, the physician may be a doctor of podiatric medicine, provided the services are consistent with the functions he or she is authorized to perform under State law and, if the services are furnished in an institution or agency, with the policy of that institution or agency.)

(iii) The services were furnished under a plan of treatment that meets the requirements of § 424.25.

(2) *Timing.* The certification statement must be obtained at the time the plan of treatment is established, or as soon thereafter as possible.

(3) *Signature.* (i) If the plan of treatment is established by a physician, the certification must be signed by that physician.

(ii) If the plan of treatment is established by a physician therapist or speech pathologist, the certification must be signed by a physician who has knowledge of the case.

(4) *Recertification*—(i) *Timing.* Recertification statements are required at least every 30 days and must be signed by the physician who reviews the plan of treatment.

(ii) *Content.* The continuing need for physical therapy or speech pathology services and an estimate of how much longer the services will be needed.

(d) *Home dialysis support services: Content of certification.* A physician must certify that the services are furnished in accordance with a written plan of treatment established and periodically reviewed by a team that includes the patient's physician and other professionals familiar with the patient's condition.

(e) *All other covered medical and other health services furnished by providers*—(1) *Content of certification.* The services were medically necessary.

(2) *Signature.* The certificate must be signed by a physician who has knowledge of the case.

(3) *Timing.* The physician may provide certification at the time the services are furnished or, if services are provided on a continuing basis, either at the beginning or at the end of a series of visits.

(4) *Recertification.* Recertification of continued need for services is not required.

§ 424.25 Plan of treatment requirements for outpatient physician therapy and speech pathology services.

(a) *Basic requirement.* Outpatient physical therapy services (including services furnished by a qualified

physical therapist in independent practice), and outpatient speech pathology services must be furnished under a written plan of treatment that meets the requirements of paragraphs (b) through (e) of this section.

(b) *Establishment of the plan.* The plan is established before treatment is begun by one of the following: [1]

(1) A physician.

(2) A physical therapist who will furnish the physical therapy services.

(3) A speech pathologist who will furnish the speech pathology services.

(c) *Content of the plan.* The plan prescribes the type, amount, frequency, and duration of the physical therapy or speech pathology services to be furnished to the individual, and indicates the diagnosis and anticipated goals.

(d) *Changes in the plan.* Any changes in the plan—

(1) Are made in writing and signed by one of the following:

(i) The physician or the physical therapist or speech pathologist who furnishes the services.

(ii) A registered professional nurse or a staff physician, in accordance with oral orders from the physician, physical therapist, or speech pathologist who furnishes the services.

(2) The changes are incorporated in the plan immediately.

(e) *Review of the plan.* (1) The physician reviews the plan as often as the individual's condition requires, but at least as often as the physician recertifies the continued need for services.

(2) Each review is dated and signed by the physician who performs it.

§ 424.27 Requirements for comprehensive outpatient rehabilitation facility (CORF) services.

Medicare Part B pays for CORF services only if a physician certifies, and the facility physician recertifies, the content specified in paragraphs (a) and (b)(2) of this section, as appropriate.

(a) *Certification: Content.* (1) The services were required because the individual needed skilled rehabilitation services;

(2) The services were furnished while the individual was under the care of a physician; and

(3) A written plan of treatment has been established and is reviewed periodically by a physician.

[1] Before January 1981, only a physician could establish a plan of treatment for physical therapy or speech pathology services. Speech pathologists were authorized to establish a plan effective January 1, 1981; physical therapists, effective July 18, 1984.

(b) *Recertification*—(1) *Timing.* Recertification is required at least every 60 days, based on review by a facility physician who, when appropriate, consults with the professional personnel who furnish the services.

(2) *Content.* (i) The plan is being followed;

(ii) The patient is making progress in attaining the rehabilitation goals; and

(iii) The treatment is not having any harmful effect on the patient.

Subpart C—Claims for Payment

§ 424.30 Scope.

This subpart sets forth the requirements, procedures, and time limits for claiming Medicare payments. Claims must be filed in all cases except when services are furnished on a prepaid capitation basis by the health maintenance organization (HMO), a competitive medical plan (CMP), or a heatlth care prepayment plan (HCPP). Special procedures for claiming payment after the beneficiary has died and for certain bills paid by organizations are set forth in Subpart E of this part.

§ 424.32 Basic requirements for all claims.

(a) All claims must be—

(1) Filed with the appropriate intermediary or carrier on a form prescribed by HCFA and in accordance with HCFA instructions;

(2) Signed by the beneficiary or the beneficiary's representative (in accordance with § 424.36(b)) unless the beneficiary has died; and

(3) Filed within the time limits specified in § 424.44.

(b) The prescribed forms for claims are the following:

HCFA–1450—Uniform Institutional Provider Bill. (This form is for institutional provider billing for Medicare inpatient, outpatient and home health services.)

HCFA–1490S—Request for Medicare payment. (For use by a patient to request payment for medical expenses.)

HCFA–1490U—Request for Medicare Payment by Organization. (For use by an organization requesting payment for medical services.)

HCFA–1491—Request for Medicare Payment-Ambulance. (For use by an organization requesting payment for ambulance services.)

HCFA–1500—Health Insurance Claim Form. (For use by physicians and suppliers to request payment for medical services.)

HCFA–1660—Request for Information-Medicare Payment for Services to a Patient now Deceased. (For use in requesting amounts payable under title XVIII to a deceased beneficiary.)

(c) *Where claims forms are available.* Excluding forms HCFA–1450 and HCFA–1500, all claims forms prescribed for use in the Medicare program are distributed free-of-charge to the public, institutions, or organizations. The HCFA–1450 and HCFA–1500 may be obtained only by commercial purchase. All other claims forms can be obtained upon request from HCFA or any Social Security branch or district office, or from Medicare intermediaries or carriers. The HCFA–1490S is also available at local Social Security Offices.

§ 424.33 Additional requirements: Claims for services of providers and claims by suppliers and nonparticipating hospitals.

All claims for services of providers and all claims by suppliers and nonparticipating hospitals must be—

(a) Filed by the provider, supplier, or hospital; and

(b) Signed by the provider, supplier, or hospital unless HCFA instructions waive this requirement.

§ 424.34 Additional requirements: Beneficiary's claim for direct payment.

(a) *Basic rule.* A beneficiary's claim for direct payment for services furnished by a supplier, or by a nonparticipating hospital that has not elected to claim payment for emergency services, must include an itemized bill or a "report of services", as specified in paragraphs (b) and (c) of this section.

(b) *Itemized bill from the hospital or supplier.* The itemized bill for the services, which may be receipted or unpaid, must include all of the following information:

(1) The name and address of—

(i) The beneficiary;

(ii) The supplier or nonparticipating hospital that furnished the services; and

(iii) The physician who prescribed the services if they were furnished by a supplier other than the physician.

(2) The place where each service was furnished, e.g., home, office, independent laboratory, hospital.

(3) The date each service was furnished.

(4) A listing of the services in sufficient detail to permit determination of reasonable charges. (For example, a bill for ambulance service must specify the pick-up and delivery points.)

(5) The charges for each service.

(c) *Report of services furnished by a supplier.* For Medicare Part B services furnished by a supplier, the beneficiary claims may include the "Report of Services" portion of the appropriate claims form, completed by the supplier in accordance with HCFA instructions, in lieu of an itemized bill.

§ 424.36 Signature requirements.

(a) *General rule.* The beneficiary's own signature is required on the claim

unless the beneficiary has died or the provisions of paragraph (b), (c), or (d) of this section apply.

(b) *Who may sign when the beneficiary is incapable.* If the beneficiary is physically or mentally incapable of signing the claim, the claim may be signed on his or her behalf by one of the following:

(1) The beneficiary's legal guardian.

(2) A relative or other person who receives social security or other governmental benefits on the beneficiary's behalf.

(3) A relative or other person who arranges for the beneficiary's treatment or exercises other responsibility for his or her affairs.

(4) A representative of an agency or institution that did not furnish the services for which payment is claimed but furnished other care, services, or assistance to the beneficiary.

(5) A representative of the provider or of the nonparticipating hospital claiming payment for services in has furnished if the provider or nonparticipating hospital is unable to have the claim signed in accordance with paragraph (b) (1), (2), (3), or (4) of the this section.

(c) *Who may sign if the beneficiary was not present for the service.* If a provider, nonparticipating hospital, or supplier files a claim for services that involved no personal contact between the provider, hospital, or supplier and the beneficiary (for example, a physician sent a blood sample to the provider for diagnostic tests), a representative of the provider, hospital, or supplier may sign the claim on the beneficiary's behalf.

(d) *Acceptance of other signatures for good cause.* If good cause is shown, HCFA may honor a claim signed by a party other than those specified in paragraphs (a) through (c) of this section.

§ 424.37 Evidence of authority to sign on behalf of the beneficiary.

(a) *Beneficiary incapable.* When a party specified in § 424.36(b) signs a claim or request for payment statement, he or she must also submit a brief statement that—

(1) Describes his or her relationship to the beneficiary; and

(2) Explains the circumstances that make it impractical for the beneficiary to sign the claim or statement.

(b) *Beneficiary not present for services.* When a representative of the provider, nonparticipating hospital, or supplier signs a claim' or request for payment statement under § 424.36(c), he or she must explain why it was not possible to obtain the beneficiary's signature. (For example: "Patient not physically present for test.")

§ 424.40 Request for payment effective for more than one claim.

(a) *Basic procedure.* A separate request for payment statement prescribed by HCFA and signed by the beneficiary (or by his or her representative) may be included in claims by reference, in the circumstances specified in paragraphs (b) through (d) of this section.

(b) *Claims filed by a provider or nonparticipating hospital.*—(1) *Inpatient services.* A signed request for payment statement, included in the first claim for Part A services furnished by a facility (a participating hospital or SNF, or a nonparticipating hospital that has elected to claim payment) during a beneficiary's period of confinement, may be effective for all claims for Part A services the facility furnishes that beneficiary during that confinement.

(2) *Home health services and outpatient physical therapy or speech pathology services.* A signed request for payment statement, included in the first claim for home health services or outpatient physical therapy or speech pathology services furnished by a provider under a plan of treatment, may be effective for all claims for home health services or outpatient physical therapy or speech pathology services furnished by the provider under that plan of treatment.

(c) *Signed statement in the provider record.*—(1) *Services to inpatients.* A signed request for payment statement in the files of a participating hospital or SNF may be effective for all claims for services furnished to the beneficiary during a single inpatient stay in that facility—

(i) By the hospital or SNF;

(ii) By physicians, if their services are billed by the hospital or SNF in its name; or

(iii) By physicians who bill separately, if the services were furnished in the hospital or SNF.

(2) *Services to outpatients: Providers and renal dialysis facilities.* A signed request for payment statement retained in the provider's or facility's files may be effective indefinitely, for all claims for services furnished to that beneficiary on an outpatient basis—

(i) By the provider or facility;

(ii) By physicians whose services are billed by the provider or facility in its name; or

(iii) By physicians who bill separately, if the services were furnished in the provider or facility.

(3) *Services to outpatients: Independent rural health clinics.* A signed request for payment statement retained in the clinic's files may be effective indefinitely for all claims for services furnished to that beneficiary by the clinic.

(d) *Signed statement in the supplier's record.* A signed request for payment statement retained in the supplier's file may be effective indefinitely subject to the following restrictions:

(1) This policy does not apply to unassigned claims for rental of durable medical equipment (DME).

(2) With respect to assigned claims for rental or purchase of DME, a new statement is required if another item of equipment is rented or purchased.

§ 424.44 Time limits for filing claims.

(a) *Basic limits.* Except as provided in paragraph (b) of this section, the claim must be mailed or delivered to the intermediary or carrier, as appropriate—

(1) On or before December 31 of the following year for services that were furnished during the first 9 months of a calendar year; and

(2) On or before December 31 of the second following year for services that were furnished during the last 3 months of the calendar year.

(b) *Extension of filing time because of error or misrepresentation.* (1) The time for filing a claim will be extended if failure to meet the deadline in paragraph (a) of this section was caused by error or misrepresentation of an employee, intermediary, carrier, or agent of the Department that was performing Medicare functions and acting within the scope of its authority.

(2) The time will be extended through the last day of the 6th calendar month following the month in which the error or misrepresentation is corrected.

(c) *Extension of period ending on a nonworkday.* If the last day of the period allowed under paragraph (a) or (b) of this section falls on a Federal nonworkday (a Saturday, Sunday, legal holiday, or a day which by statute or Executive Order is declared to be a nonworkday for Federal employees), the time is extended to the next succeeding workday.

§ 424.45 What constitutes a claim for purposes of meeting the time limits.

A written statement of intent to claim Medicare benefits constitutes a claim if—

(a) The statement is filed with HCFA or any carrier or intermediary within the time limits specified in § 424.44;

(b) The statement indicates the intent to claim Medicare payment for specified services furnished to an identified beneficiary; and

(c) A claim that meets the requirements of § 424.32(a) is filed within 6 months after the month in which the intermediary or carrier, as appropriate, advises the claimant to file that claim.

Subpart D—To Whom Payment Is Ordinarily Made

§ 424.50 Scope.

(a) This subpart specifies to whom Medicare payment is ordinarily made for different kinds of services.

(b) Subpart E of this part sets forth provisions applicable in special situations.

(c) Subpart F of this part specifies the exceptional circumstances under which payment may be made to an assignee or reassignee.

§ 424.51 Payment to the provider.

(a) *Basic rule.* Except as specified in paragraph (b) of this section, Medicare pays the provider for services furnished by a provider.

(b) *Exception.* Medicare pays the beneficiary for outpatient hospital services if the hospital has collected an amount in excess of the unmet deductible and coinsurance, as specified in § 489.30(b)(4) of this chapter,

§ 424.52 Payment to a nonparticipating hospital.

Medicare pays a nonparticipating hospital for the following services, if covered, in the specified circumstances:

(a) Emergency inpatient and outpatient services furnished by a U.S. hospital, if the hospital has in effect an election to claim payment in accordance with Subpart G of this part.

(b) Certain medical and other health services covered under Medicare Part B and furnished by a U.S. hospital, if the hospital meets the requirements of § 424.55 for payment as a supplier.

(c) Emergency or nonemergency inpatient services furnished by a foreign hospital if the hospital has in effect an election to claim payment in accordance with Subpart G of this part.

§ 424.53 Payment to the beneficiary.

Medicare pays the beneficiary for the following services, if covered, in the specified circumstances:

(a) Emergency inpatient and outpatient services furnished by a nonparticipating U.S. hospital that has not elected to claim payment in accordance with Subpart G of this part.

(b) Certain medical and other health services covered under Medicare Part B and furnished by a nonparticipating U.S. hospital, if the hospital does not receive assigned payment as a supplier under § 424.55

(c) Emergency or nonemergency services furnished by a foreign hospital if the hospital does not have in effect an election to claim payment in accordance with Subpart H of this part.

(d) Physician and ambulance services furnished outside the United States.

(e) Services furnished by a supplier if the claim has not been assigned to the supplier.

§ 424.54 Payment to the beneficiary's legal guardian or representative payee.

Medicare may pay amounts due a beneficiary to the beneficiary's legal guardian or representative payee.

§ 424.55 Payment to the supplier

(a) Medicare pays the supplier for covered services if the beneficiary (or the person authorized to request payment on the beneficiary s behalf) assigns the claim to the supplier and the supplier accepts assignment.

(b) In accepting assignment, the supplier agrees to the following:

(1) To accept, as full charge for the service, the amount the carrier determines to be the reasonable charge.

(2) To limit charges to the beneficiary or any other source as follows:

(i) To collect nothing for those services for which Medicare pays 100 percent of the reasonable charge.

(ii) To collect only the amount of the unmet deductible, plus 20 percent of the difference between the reasonable charge and the unmet deductible for those services for which Medicare pays 80 percent of that difference.

(3) Not to charge the beneficiary when Medicare paid for services determined to be "not reasonable or necessary" if—

(i) The beneficiary was without fault in the overpayment; and

(ii) The determination that the payment was incorrect was made by the carrier after the third year following the year in which the carrier sent notice to the beneficiary that it approved the payment.

§ 424.56 Payment to a beneficiary and to a supplier.

(a) *Conditions for split payment.* If the beneficiary assigns the claim after paying part of the bill, payment may be made partly to the beneficiary and partly to the supplier.

(b) *Payment to the supplier.* Payment to the supplier who submits the assigned claim is for whichever of the following amounts is less:

(1) The reasonable charge minus the amount the beneficiary had already paid to the supplier; or

(2) The full Part B benefit due for the services furnished.

(c) *Payment to the beneficiary.* Any part of the Part B benefit which, on the basis of paragraph (b) of this section, is not payable to the supplier, is paid to the beneficiary.

(d) *Examples.*

Example 1. An assigned bill of $300 on which partial payment of $100 has been paid is submitted to the carrier. The carrier determines that $300 is the reasonable charge for the services furnished, and $50 of the supplementary medical insurance benefits deductible has previously been met. Total payment due is 80 percent of $275 ($300 minus the remaining $25 of the deductible), or $220. Of this amount, $200 will be paid to the person or organization that furnished the services (the difference between the $100 partial payment which the person or organization has already received, and the $300 amount of the reasonable charge). The $20 will be paid to the beneficiary

Example 2. An assigned bill of $325 on which partial payment of $275 has been paid is submitted to the carrier. The carrier determines that $275 is the reasonable charge for the services furnished, and no part of the supplementary medical insurance benefits deductible has been previously met. Total payment due is 80 percent of $200 ($275 reasonable charge minus $75 deductible) deductible, or $160. The $160 is payable to the beneficiary, since any payment to the supplier, when added to the amount of the partial payment, will exceed the reasonable charge for the services furnished.

Subpart E—To Whom Payment is Made in Special Situations

§ 424.60 Scope.

(a) This subpart contains provisions applicable to payment after the beneficiary's death and payment to certain organizations.

(b) The provisions applicable to payment for services excluded as custodial care or services not reasonable and necessary are set forth in §§ 405.332 through 405.336 of this chapter.

§ 424.62 Payment after beneficiary's death: Bill has been paid.

(a) *Scope.* This section specifies the persons whom Medicare pays, and the conditions for payments, when the beneficiary has died and the bill has been paid.

(b) *Situation.*

(1) The beneficiary has received covered services for which he could receive direct payment under § 424.53.

(2) The beneficiary died without receiving Medicare payment.

(3) The bill has been paid.

(c) *Persons whom Medicare pays.* In the situation described in paragraph (b) of this section, Medicare pays the following persons in the specified circumstances:

(1) The person or persons who, without a legal obligation to do so, paid

for the services with their own funds, before or after the beneficiary's death.

(2) The legal representative of the beneficiary's estate if the services were paid for by the beneficiary before he or she died, or with funds from the estate.

(3) If the deceased beneficiary or his or her estate paid for the services and no legal representative of the estate has been appointed, the survivors, in the following order of priority:

(i) The person found by SSA to be the surviving spouse, if he or she was either living in the same household with the deceased at the time of death, or was, for the month of death, entitled to monthly social security or railroad retirement benefits on the basis of the same earnings record as the deceased beneficiary;

(ii) The child or children, who were, for the month of death, entitled to monthly social security or railroad retirement benefits on the basis of the same earnings record as the deceased (and, if there is more than one child, in equal parts to each child);

(iii) The parent or parents, who were, for the month of death, entitled to monthly social security or railroad retirement benefits on the basis of the same earnings record as the deceased (and, if there is more than one parent, in equal parts to each parent);

(iv) The person found by SSA to be the surviving spouse who was not living in the same household with the deceased at the time of death and was not, for the month of death, entitled to monthly social security or railroad retirement benefits on the basis of the same earnings record as the deceased beneficiary;

(v) The child or children who were not entitled to monthly social security or railroad retirement benefits on the basis of the same earnings record as the deceased (and, if there is more than one child, in equal parts to each child);

(vi) The parent or parents who were not entitled to monthly social security or railroad retirement benefits on the basis of the same earnings record as the deceased (and, if there is more than one parent, in equal parts to each parent).

(4) If none of the listed relatives survive, no payment is made.

(5) If the services were paid for by a person other than the deceased beneficiary, and that person died before payment was completed, Medicare does not pay that person's estate. Medicare pays a surviving relative of the deceased beneficiary in accordance with the priorities in paragraph (c)(3) of this section. If none of those relatives survive. Medicare pays the legal representative of the deceased beneficiary's estate. If there is no legal representative of the estate, no payment is made.

(d) *Amount of payment.* The amount of payment is the amount due, including unnegotiated checks issued for the purpose of making direct payment to the beneficiary.

(e) *Conditions for payment.* For payment to be made under this section—

(1) The person who claims payment must meet the following requirements:

(i) Submit a claim on a HCFA-prescribed form and an itemized bill in accordance with the requirements of this subpart. (See paragraph (g) of this section for an exception.)

(ii) Provide evidence that the services were furnished if the intermediary or carrier requests it.

(iii) Provide evidence of payment of the bill and of the identity of the person who paid it.

(2) If a person claims payment as the legal representative of the deceased beneficiary's estate, he or she must also submit a copy of the papers showing appointment as legal representative.

(3) If a person claims payment as a survivor of the beneficiary, he or she must also submit evidence, if the intermediary or carrier requests it, that he or she is highest on the priority list of paragraph (c)(3) of this section.

(f) *Evidence of payment.* Evidence of payment may be—

(1) A receipted bill, or a properly completed "Report of Services" section of a claim form, showing who paid the bill;

(2) A cancelled check;

(3) A written statement from the provider or supplier or an authorized staff member; or

(4) Other probative evidence.

(g) *Exception: Claim submitted before beneficiary died.* If a claim and itemized bill has been submitted by or on behalf of the beneficiary before he or she died, submission of another claim form and itemized bill is not required; any written request by the person seeking payment is sufficient.

§ 424.64 Payment after beneficiary's death: Bill has not been paid.

(a) *Scope.* This section specifies whom Medicare pays, and the conditions for payment when the beneficiary has died and the bill has not been paid.

(b) *Situation.* (1) The beneficiary has received covered Part B services furnished by a physician or other supplier.

(2) The beneficiary died without making an assignment to the physician or other supplier or receiving Medicare payment.

(3) The bill has not been paid.

(c) *To whom payment is made.* In the situation described in paragraph (b) of this section, Medicare pays as follows:

(1) *Payment to the supplier.* Medicare pays the physician or other supplier if he or she—

(1) Files a claim on a HCFA-prescribed form in accordance with the applicable requirements of this subpart;

(ii) Upon request from the carrier, provides evidence that the services for which it claims payment were, in fact, furnished; and

(iii) Agrees in writing to accept the reasonable charge as the full charge for the services.

(2) *Payment to a person who assumes legal obligation to pay for the services.* If the physician or other supplier does not agree to accept the reasonable charge as full charge for the service, Medicare pays any person who submits to the carrier all of the following:

(1) A statement indicating that he or she has assumed legal obligation to pay for the services.

(ii) A claim on a HCFA-prescribed form in accordance with the requirements of this subpart. (If a claim had been submitted by or on behalf of the beneficiary before he or she died, submission of another claim form is not required; a written request by the person seeking payment meets the requirement for a claim.)

(iii) An itemized bill that identifies the claimant as the person to whom the physician or other supplier holds responsible for payment. (If such an itemized bill had been submitted by or on behalf of the beneficiary before he or she died, submission of another itemized bill is not required.)

(iv) If the intermediary or carrier requests it, evidence that the services were actually furnished.

§ 424.66 Payment to organizations.

(a) *Qualified organizations.* The following organizations may receive payment under this section for Medicare Part B services furnished by a supplier:

(1) Employers, unions, employer-employee organizations, and insurers for such entities; and

(2) Prepaid health plans.

(b) *Qualified services.* The following Medicare Part B services furnished by a supplier qualify for payment under this section.

(1) Services covered under an employment-related group health insurance plan of an organization specified in paragraph (a)(1) of this section.

(2) Services that are covered under a prepaid health plan but are not reimbursed under regular procedures for

payment to a prepayment plan because they were furnished by a supplier from which the plan has not arranged to obtain services. An example would be services furnished to a prepayment plan member while he or she is traveling.

(c) *Conditions for payment.* Medicare reimburses an organization identified in paragraph (a) of this section for its payment for Medicare Part B services furnished by suppliers, if the following conditions are met:

(1) The organization has paid in full the charges for the services for which it claims reimbursement.

(2) The organization has written authorization to request payment on the beneficiary's behalf, and to receive reimbursement for charges that the organization has paid in full.

(3) The organization relieves the beneficiary of liability for payment for the services specified in the claim and agrees not to seek any payment from the beneficiary or the beneficiary's survivors or estate if Medicare pays the organization for those services.

(4) The organization establishes to the satisfaction of HCFA or the carrier that it is one of the organizations specified in paragraph (a) of this section, and that the services are among those specified in paragraph (b) of this section.

(5) The organization files a claim for the services in accordance with § 424.32.

(6) The organization includes with the claim an itemized bill or the Report of Services of the supplier in accordance with § 424.34.

(7) The organization submits any other information that HCFA or the carrier requests in order to apply the requirements for payment for the services

(d) *Organization's discretion to limit claims.* An organization is not required to pay and claim reimbursement for all Medicare Part B services furnished to a beneficiary. The organization may, on the basis of established criteria, select the Part B services for which it will pay.

Subpart F—Limitations on Assignment and Reassignment of Claims

§ 424.70 Basis and scope.

(a) *Statutory basis.* This subpart implements sections 1815(c) and 1842(b)(6) of the Act, which establish limitations on who may receive payments due a provider or supplier of services or a beneficiary.

(b) *Scope.* This subpart—

(1) Prohibits the assignment, reassignment, or other transfer of the right to Medicare payments except under specified conditions;

(2) Sets forth the sanctions that HCFA may impose on a provider or supplier that violates this prohibition, or on a supplier that violates the conditions to which it agreed in accepting assignment from the individual; and

(3) Specifies the conditions for payment under court-ordered assignments or reassignments.

§ 424.71 Definitions.

As used in this subpart, unless the context indicates otherwise—

"Court of competent jurisdiction" means a court that has jurisdiction over the subject matter and the parties before it.

"Facility" means a hospital or other institution that furnishes health care services to inpatients.

"Health care delivery system" or *"system"* means a public or private organization for delivering health services. The term includes, but is not limited to, clinics and health care prepayment plans.

"Power of attorney" means any written documents by which a principal authorizes an agent to—

(1) Receive, in the agent's name, any payments due the principal;

(2) Negotiate checks payable to the principal; or

(3) Receive, in any other manner, direct payment of amounts due the principal.

§ 424.73 Prohibition of assignment of claims by providers.

(a) *Basic prohibition.* Except as specified in paragraph (b) of this section, Medicare does not pay amounts that are due a provider to any other person under assignment, or power of attorney, or any other direct payment arrangement.

(b) *Exceptions to the prohibition.*—(1) *Payment to a government agency or entity.* Subject to the requirements of the Assignment of Claims Act (31 U.S.C. 3727), Medicare may pay a government agency or entity under an assignment by the provider.

(2) *Payment under assignment established by court order.* Medicare may pay under an assignment established by, or in accordance with, the order of a court of competent jurisdiction if the assignment meets the conditions set forth in § 424.90.

(3) *Payment to an agent.* Medicare may pay an agent who furnishes billing and collection services to the provider if the following conditions are met:

(i) The agent receives the payment under an agency agreement with the provider;

(ii) The agent's compensation is not related in any way to the dollar amounts billed or collected;

(iii) The agent's compensation is not dependent upon the actual collection of payment;

(iv) The agent acts under payment disposition instructions that the provider may modify or revoke at any time; and

(v) The agent, in receiving the payment, acts only on behalf of the provider.

Payment to an agent will always be made in the name of the provider.

§ 424.74 Termination of provider agreement.

HCFA may terminate a provider agreement, in accordance with § 489.53(a)(1) of this chapter, if the provider—

(a) Executes or continues a power of attorney, or enters into or continues any other arrangement, that authorizes or permits payment contrary to the provisions of this subpart; or

(b) Fails to furnish, upon request by HCFA or the intermediary, evidence necessary to establish compliance with the requirements of this subpart.

§ 424.80 Prohibition of reassignment of claims by suppliers.

(a) *Basic prohibition.* Except as specified in paragraph (b) of this section, Medicare does not pay amounts that are due a supplier under an assignment to any other person under reassignment, power of attorney, or any other direct arrangement.

(b) *Exceptions to the basic rule.*—(1) *Payment to employer.* Medicare may pay the supplier's employer if the supplier is required, as a condition of employment, to turn over to the employer the fees for his or her services.

(2) *Payment to a facility.* Medicare may pay the facility in which the services were furnished if there is a contractual arrangement between the facility and the supplier under which the facility bills for the supplier's services.

(3) *Payment to health care delivery system.* Medicare may pay a health care delivery system if there is a contractual arrangement between the system and the supplier under which the system bills for the supplier's services.

(4) *Payment to a government agency or entity.* Subject to the requirements of the Assignment of Claims Act (31 U.S.C. 3727), Medicare may pay a government agency or entity under a reassignment by the supplier.

(5) *Payment under a reassignment established by court order.* Medicare may pay under a reassignment established by, or in accordance with, the order of a court competent jurisdiction, if the reassignment meets the conditions set forth in § 424.90.

(6) *Payment to an agent.* Medicare may pay an agent who furnishes billing and collection services to the supplier, or to the employer, facility, or system specified in paragraphs (b) (1), (2) and (3) of this section, if the conditions of § 411.73(b)(3) for payment to a provider's agent are met by the agent of the supplier or of the employer, facility, or system. Payment to an agent will always be made in the name of the supplier or the employer, facility, or system.

(c) *Rules applicable to an employer, facility, or system.* An employer, facility, or system that may receive payment under paragraph (b)(1), (b)(2), or (b)(3) of this section will itself be considered the supplier of those services for purposes of the rules of Subparts C, D, and E of this part.

§ 424.82 Revocation of right to receive assigned benefits.

(a) *Scope.* This section sets forth the conditions and procedures for revocation of the right of a supplier or other party to receive Medicare payments.

(b) *Definition.* As used in this section, *"other party"* means an employer, facility, or health care delivery system to which Medicare may make payment under § 424.80(b) (1), (2), or (3).

(c) *Basis for revocation.* HCFA may revoke the right of a supplier or other party to receive Medicare payments if the supplier or other party, after warning by HCFA or the carrier—

(1) Violates the terms of assignment in § 424.55(b).

(2) Continues collection efforts or fails to refund moneys incorrectly collected, in violation of the terms of assignment in § 424.55(b).

(3) Executes or continues in effect a reassignment0 or power of attorney or any other arrangement that seeks to obtain payment to the provisions of § 424.80; or

(4) Fails to furnish evidence necessary to establish its compliance with the requirements of § 424.80.

(d) *Proposed revocation: Notice and opportunity for review.* If HCFA proposes to revoke the right to payment in accordance with paragraph (c) of this section, it will send the supplier or other party a written notice that—

(1) States the reasons for the proposed revocation; and

(2) Provides an opportunity for the supplier or other party to submit written argument and evidence against the proposed revocation. HCFA usually allows 15 days from the date on the notice, but.may extend or reduce the time as circumstances require

(e) *Actual revocation: Timing, notice, and opportunity for hearing*—(1) *Timing.* HCFA determines whether to revoke after considering any written argument or evidence submitted by the supplier or other party or, if none is submitted, at the expiration of the period specified in the notice of proposed revocation.

(2) *Notice and opportunity for hearing.* The notice of revocation specifies—

(i) The reasons for the revocation;

(ii) That the revocation is effective as of the date on the notice;

(iii) That the supplier or other party may, within 60 days from the date on the notice (or a longer period if the notice so specifies), request an administrative hearing and may be represented by counsel or other qualified representative.

(iv) That the carrier will withhold payment on any claims submitted by the supplier or other party until the period for requesting a hearing expires or, if a hearing is requested, until the hearing officer issues a decision;

(v) That if the hearing decision reverses the revocation, the carrier will pay the supplier's or other party's claims; and

(vi) That if a hearing is not requested or the hearing decision upholds the revocation, payment will be made to the beneficiary or to another person or agency authorized to receive payment on his or her behalf.

§ 424.83 Hearings on revocation of right to receive assigned benefits.

If the supplier or other party requests a hearing under § 424.82(e)(2)—

(a) The hearing is conducted—

(1) By a HCFA hearing official who was not involved in the decision to revoke; and

(2) In accordance with the procedures set forth in §§ 405.824 through 405.833 (but excepting § 405.832(d)) and 405.860 through 405.872 of this chapter. In applying those procedures, "HCFA" is substituted for "carrier"; and "hearing official", for "hearing officer".

(b) As soon as practicable after the close of the hearing, the official who conducted it issues a hearing decision that—

(1) Is based on all the evidence presented at the hearing and included in the hearing record; and

(2) Contains findings of fact and a statement of reasons.

§ 424.84 Final determination on revocation of right to receive assigned benefits.

(a) *Basis of final determination.*—(1) *Final determination without a hearing.* If the supplier or other party does not request a hearing, HCFA's revocation determination becomes final at the end of the period specified in the notice of revocation.

(2) *Final determination following a hearing.* If there is a hearing, the hearing decision constitutes HCFA s final determination.

(b) *Notice of final determination.* HCFA sends the supplier or other party a written notice of the final determination and, if there was a hearing, includes a copy of the hearing decision.

(c) *Application of the final determination.*—(1) A final determination not to revoke is the final administrative decision by HCFA on the matter.

(2) A final determination to revoke remains in effect until HCFA finds that the reason for the revocation has been removed and that there is reasonable assurance that it will not recur.

(3) A final determination to revoke also applies to any corporation, partnership, or other entity in which the supplier or other party directly or indirectly has obtained or obtains all, or all but a nominal part, of the financial interest.

§ 424.86 Prohibition of assignment of claims by beneficiaries.

(a) *Basic prohibition.* Except as specified in paragraph (b) of this section, Medicare does not pay amounts that are due a beneficiary under § 424.53 to any other person under assignment, power of attorney, or any other direct payment arrangement.

(b) *Exceptions.*—(1) *Payment to a government agency or entity.* Subject to the requirements of the Assignment of Claims Act (31 U.S.C. 3727), Medicare may pay a government agency or entity under an assignment by a beneficiary (or by the beneficiary's legal guardian or representative payee).

(2) *Payment under an assignment established by court order.* Medicare may pay under an assignment established by, or in accordance with, a court order if the assignment meets the conditions set forth in § 424.90.

§ 424.90 Court ordered assignments: Conditions and limitations.

(a) *Conditions for acceptance.* An assignment or reassignment established by or in accordance with a court order is effective for Medicare payments only if—

(1) Someone files a certified copy of the court order and of the executed assignment or reassignment (if it was necessary to execute one) with the intermediary or carrier responsible for processing the claim; and

(2) The assignment or reassignment—

(i) Applies to all Medicare benefits payable to a particular person or entity during a specified or indefinite time period; or

(ii) Specifies a particular amount of money, payable to a particular person or entity by a particular intermediary or carrier.

(b) *Retention of authority to reduce interim payments to providers.* A court-ordered assignment does not preclude the intermediary or carrier from reducing interim payments, as set forth in § 413.64(i) of this chapter, if the provider or assignee is in imminent danger of insolvency or bankruptcy.

(c) *Liability of the parties.* The party that receives payments under a court-ordered assignment or reassignment that meets the conditions of paragraph (a) of this section and the party that would have received payment if the court order had not been issued are jointly and . severally responsible for any Medicare overpayment to the former.

Subpart G—Special Conditions: Emergency Services Furnished by a Nonparticipating Hospital

§ 424.100 Scope.

This subpart sets forth procedures and criteria that are followed in determining whether Medicare will pay for emergency services furnished by a hospital that is located in the United States and does not have in effect a provider agreement, that is, an agreement to participate in Medicare.

§ 424.101 Definitions.

As used in this subpart, unless the context indicates otherwise—

"Emergency services" means inpatient or outpatient hospital services that are necessary to prevent death or serious impairment of health and, because of the danger to life or health, require use of the most accessible hospital available and equipped to furnish those services.

"Hospital" means a facility that—

(1) Is primarily engaged in providing, by or under the supervision of doctors of medicine or osteopathy, inpatient services for the diagnosis, treatment, and care or rehabilitation of persons who are sick, injured, or disabled;

(2) Is not primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care, as described in section 1861(j)(1)(A) of the Act;

(3) Provides 24-hour nursing service in accordance with section 1861(e)(5) of the Act; and

(4) Is licensed, or is approved as meeting the standards for licensing, by the State or local licensing agency.

"Reasonable charges" means customary charges insofar as they are reasonable.

§ 424.102 Situations that do not constitute an emergency.

Without additional evidence of a threat to life or health, the following situations do not in themselves indicate a need for emergency services:

(a) Lack of care at home.

(b) Lack of transportation to a participating hospital.

(c) Death of the patient in the hospital.

§ 424.103 Conditions for payment for emergency services.

Medicare pays for emergency services furnished to a beneficiary by a nonparticipating hospital or under arrangements made by such a hospital if the conditions of this section are met.

(a) *General requirements.* (1) The services are of the type that Medicare would pay for if they were furnished by a participating hospital.

(2) The hospital has in effect an election to claim payment for all emergency services furnished in a calendar year in accordance with § 424.104.

(3) The need for emergency services arose while the beneficiary was not an inpatient in a hospital.

(4) In the case of inpatient hospital services, the services are furnished during a period in which the beneficiary could not be safely discharged or transferred to a participating hospital or other institution.

(5) The determination that the hospital was the most accessible hospital available and equipped to furnish the services is made in accordance with § 424.106.

(b) *Medical information requirements.* A physician (or, if appropriate, the hospital) submits medical information that—

(1) Describes the nature of the emergency and specifies why it required that the beneficiary be treated in the most accessible hospital;

(2) Establishes that all the conditions in paragraph (a) of this section are met; and

(3) Indicates when the emergency ended, which, for inpatient hospital services, is the earliest date on which the beneficiary could be safely discharged or transferred to a participating hospital or other institution.

§ 424.104 Election to claim payment for emergency services furnished during a calendar year.

(a) *Terms of the election.* The hospital agrees to the following:

(1) To comply with the provisions of Subpart C of Part 489 of this chapter relating to charges for items and services the hospital may make to the beneficiary, or any other person on his or her behalf.

(2) To comply with the provisions of Subpart D of Part 489 of this chapter relating to proper disposition of monies incorrectly collected from, or on behalf of a beneficiary.

(3) To request payment under the Medicare program based on amounts specified in § 413.74 of this chapter.

(b) *Filing of election statement.* An election statement must be filed on a form designated by HCFA, signed by an authorized official of the hospital, and either received by HCFA, or postmarked, before the close of the calendar year of election.

(c) *Acceptance and effective date of election.* If HCFA accepts the election statement, the election is effective as of the earliest day of the calendar year of election from which HCFA determines the hospital has been in continuous compliance with the requirements of section 1814(d) of the Act.

(d) *Appeal by hospital.* Any hospital dissatisfied with a determination that it does not qualify to claim reimbursement shall be entitled to appeal the determination as provided in Part 498 of this chapter.

(e) *Conditions for reinstatement after notice of failure to continue to qualify.* If HCFA has notified a hospital that it no longer qualifies to receive reimbursement for a calendar year, HCFA will not accept another election statement from that hospital until HCFA finds that—

(1) The reason for its failure to qualify has been removed; and

(2) There is reasonable assurance that it will not recur.

§ 424.106 Criteria for determining whether the hospital was the most accessible.

(a) *Basic requirement.* (1) The hospital must be the most accessible one available and equipped to furnish the services.

(2) HCFA determines accessibility based on the factors specified in paragraphs (b) and (c) of this section and the conditions set forth in paragraph (d) of this section.

(b) *Factors that are considered.* HCFA considers the following factors in determining whether a nonparticipating

hospital in a rural area meets the accessibility requirements:

(1) The relative distances of participating and nonparticipating hospitals in the area.

(2) The transportation facilities available to these hospitals.

(3) The quality of the roads to each hospital.

(4) The availability of beds at each hospital.

(5) Any other factors that bear on whether or not the services could be provided sooner in the nonparticipating hospitals than in a participating hospital in the general area.

In urban and suburban areas where both participating and nonparticipating hospitals are similarly available, HCFA presumes that the services could have been provided in a participating hospital unless clear and convincing evidence shows that there was a medical or practical need to use the nonparticipating hospital.

(c) *Factors that are not considered.* HCFA gives no consideration to the following factors in determining whether the nonparticipating hospital was the most accessible hospital:

(1) The personal preference of the beneficiary, the physician, or members of the family.

(2) The fact that the attending physician did not have staff privileges in a participating hospital which was available and the most accessible to the beneficiary.

(3) The location of previous medical records.

(d) *Conditions under which the accessibility requirement is met.* If a beneficiary must be taken to a hospital immediately for required diagnosis and treatment, the nonparticipating hospital meets the accessibility requirement if—

(1) It was the nearest hospital to the point where the emergency occurred, it was medically equipped to handle the type of emergency, and it was the most accessible, on the basis of the factors specified in paragraph (b) of this section; or

(2) There was a closer participating hospital equipped to handle the emergency, but the participating hospital did not have a bed available or would not accept the individual.

§ 424.108 Payment to a hospital.

(a) *Conditions for payment.* Medicare pays the hospital for emergency services if the hospital—

(1) Has in effect a statement of election to claim payment for all covered emergency services furnished during a calendar year, in accordance with § 424.104;

(2) Claims payment in accordance with § 424.32; and

(3) Submits evidence requested by HCFA to establish that the services meet the requirements of this subpart.

(b) *Subsequent claims.* If the hospital files subsequent claims because the initial claim did not include all the services furnished, those claims must include physicians' statements that—

(1) Contain sufficient information to clearly establish that, when the additional services were furnished, the emergency still existed; and

(2) Indicate when the emergency ended, which, for inpatient hospital services, is the earliest date on which the beneficiary could be safely discharged or transferred to a participating hospital or other institution.

§ 424.109 Payment to the beneficiary.

Medicare pays the beneficiary for emergency services if the following conditions are met:

(a) The hospital does not have in effect an election to claim payment.

(b) The beneficiary, or someone on his or her behalf, submits—

(1) A claim that meets the requirements of § 424.32;

(2) An itemized hospital bill; and

(3) Evidence requested by HCFA to establish that the services meet the requirements of this subpart.

Subpart H—Special Conditions: Services Furnished in a Foreign Country

§ 424.120 Scope.

This subpart sets forth the conditions for payment for services furnished in a foreign country.

§ 424.121 Scope of payments.

Subject to the conditions set forth in this subpart—

(a) Medicare Part A pays, in the amounts specified in § 413.74 of this chapter, for emergency and nonemergency inpatient hospital services furnished by a foreign hospital.

(b) Medicare Part B pays for certain physicians' services and ambulance services furnished in connection with covered inpatient care in a foreign hospital, as specified in § 424.124.

(c) All other services furnished outside the United States are excluded from Medicare coverage, as specified in § 405.313 of this chapter.

§ 424.122 Conditions for payment for emergency inpatient hospital services.

Medicare Part A pays for emergency inpatient hospital services furnished by a foreign hospital if the following conditions are met:

(a) At the time of the emergency that required the inpatient hospital services, the beneficiary was—

(1) In the United States; or

(2) In Canada traveling between Alaska and another State without unreasonable delay and by the most direct route.

(b) The foreign hospital was closer to, or more accessible from, the site of the emergency than the nearest United States hospital equipped to deal with, and available to treat, the individual's illness or injury.

(c) The conditions for payment for emergency services set forth in § 424.103 are met.

(d) The hospital is a hospital as defined in § 424.101, and is licensed, or approved as meeting the conditions for licensing, by the appropriate agency of the country in which it is located.

(e) The determination of whether the hospital was more accessible is made in accordance with § 424.106.

§ 424.123 Conditions for payment for nonemergency inpatient services furnished by a hospital closer to the individual's residence.

Medicare Part A pays for inpatient hospital services furnished by a foreign hospital if the following conditions are met:

(a) The beneficiary is a resident of the United States.

(b) The foreign hospital is closer or more accessible to the beneficiary's residence than the nearest United States hospital equipped to deal with, and available to treat, the individual's illness or injury.

(c) The foreign hospital is—

(1) A hospital as defined in § 424.101 and, it is licensed, or approved as meeting the conditions for licensing, by the appropriate agency of the country in which it is located; and

(2) Accredited by the Joint Commission on Accreditation of Hospitals (JCAH) or accredited or approved by a program of the country where it is located under standards that HCFA finds to be essentially equivalent to those of the JCAH.

(d) The services are covered services that Medicare would pay for if they were furnished by a participating hospital.

§ 424.124 Conditions for payment for physician services and ambulance services.

(a) *Basic rules.* Medicare Part B pays for physicians and ambulance services if—

(1) They are furnished—

(i) To an individual who is entitled to Part B benefits; and

(ii) In connection with covered inpatient hospital services; and

(2) They meet the conditions set forth in paragraphs (b) and (c) of this section

(b) *Physicians' services.* (1) The physicians' services are services covered under Medicare Part B and are furnished—

(i) In the hospital, during a period of covered inpatient services; or

(ii) Outside the hospital, on the day of admission and for the same condition that required inpatient admission; and

(2) The physician is legally authorized to practice in the country where he or she furnishes the services.

(c) *Ambulance services.* The ambulance services are—

(1) Necessary because the use of other means of transportation is contraindicated by the beneficiary's condition; and

(2) Furnished by an ambulance that meets the definition in § 410.140 of this chapter.

§ 424.126 Payment to the hospital.

(a) *Conditions for payment.* Medicare pays the hospital if it—

(1) Has in effect an election that—

(i) Meets the requirements set forth in § 424.104; and

(ii) Reflects the hospital's intent to claim for all covered services furnished during a calendar year.

(2) Claims payment in accordance with §§ 424.32 and 413.74 of this chapter; and

(3) Submits evidence requested by HCFA to establish that the services meet the requirements of this subpart.

(b) *Amount of payment.* Payment is made (in accordance with § 413.74 of this chapter) on the basis of 100 percent of the hospital's customary charges, subject to the applicable deductible and coinsurance provisions set forth elsewhere in this chapter.

§ 424.127 Payment to the beneficiary.

(a) *Conditions for payment of inpatient hospital services.* Medicare pays the beneficiary if—

(1) The hospital does not have in effect an election to claim payment; and

(2) The beneficiary, or someone on his or her behalf, submits—

(i) A claim in accordance with § 424.32;

(ii) An itemized hospital bill; and

(iii) Evidence requested by HCFA to establish that the services meet the requirements of this subpart.

(b) *Amount payable for inpatient hospital services.* The amount payable to the beneficiary is determined in accordance with § 424.109(b).

(c) *Conditions for payment for Part B services.* Medicare pays the beneficiary for physicians' services and ambulance service as specified in § 424.121, if an itemized bill for the services is submitted by the beneficiary or someone on his or her behalf and the conditions of § 424.126(a) (2) and (3) are met.

(d) The amount payable to the beneficiary is determined in accordance with § 410.152 of this chapter.

Subpart I–L [Reserved]

Subpart M—Replacement and Reclamation of Medicare Payments

§ 424.350 Replacement of U.S. Government checks that are lost, stolen, defaced, mutilated, destroyed, or paid on forged endorsements.

(a) *Responsibility.* The Treasury Department is responsible for the investigation and settlement of claims in connection with Treasury checks issued on behalf of HCFA.

(b) *Action by HCFA.* HCFA forwards reports of lost, stolen, defaced, mutilated, destroyed, or forged Treasury checks to the Treasury Department disbursing center responsible for issuance of the check.

(c) *Action by the Treasury Department.* The Treasury Department will replace and begin reclamation of Treasury checks in accordance with Treasury Department regulations (31 CFR Parts 235, 240 and 245).

§ 424.352 Replacement of intermediary and carrier checks that are lost, stolen, defaced, mutilated, destroyed, or paid on forged endorsements.

(a) *HCFA's responsibility.* HCFA is responsible for coordinating the investigation and settlement of claims in connection with intermediary and carrier checks, including the determination that a check endorsement has been forged.

(b) *Action by HCFA.* HCFA:

(1) Analyzes each check suspected of having a forged endorsement to determine the authenticity of the endorsement;

(2) Grants an independent administrative review, upon request, to any payee dissatisfied with its determination; and

(3) Forwards reports concerning lost, stolen, defaced, mutilated, destroyed, or forged checks to the issuing office of the appropriate intermediary or carrier.

(c) *Action by carrier or intermediary: Outstanding check that is lost, stolen, defaced, mutilated, or destroyed.* (1) If the check has been lost or stolen and has not been paid, the carrier or intermediary must stop payment on the check and issue another check.

(2) If the check has been defaced, mutilated, or destroyed, the carrier or intermediary must recover any available remains of the check and issue a substitute check.

(d) *Action by carrier or intermediary: Forged endorsement.* The carrier or intermediary must make settlement in favor of the payee before recovering the amount of the check if—

(1) The facts show that the check was paid on a forged endorsement and the payee did not participate, directly or indirectly, in the proceeds of that payment; and

(2) The payee, or the payee's authorized representative, after examining the check or a copy of it, states in writing that to the best of his or her knowledge or belief the endorsement is not the payee's.

§ 424.354 Reclamation proceedings: Checks issued by carriers or intermediaries.

Checks issued by carriers and intermediaries are drawn on commercial banks and are not subject to the Federal laws and Treasury Department regulations that govern Treasury checks. Accordingly, when HCFA determines that a check has been paid on a forged endorsement, the carrier or intermediary must take appropriate action to recover the amount of the check, in accordance with applicable State law.

F. Technical and Conforming Amendments.

§ 400.310 [Amended]

1. In the table,

a. "405.165, 405.170" is changed to "424.5, 424.7".

b. "405.1627, 405.1629" is changed to "423.13, 424.14".

c. "405.1632" is changed to "424.20".

§ 405.311a [Amended]

2. In paragraph (a), "§ 405.152 or § 410.168" is changed to "§ 410.168 or § 424.103".

§ 405.313 [Amended]

3. In paragraph (a), "§ 405.153 (a) and (b)," is changed to "Subpart H of Part 424 of this chapter,".

§ 405.370 [Amended]

4. a. The section heading is revised to read: "§ 405.370 Suspension of Medicare payments to providers and suppliers."

b. The introductory text of paragraph (a) is revised to read:

"(a) Medicare payments to providers and suppliers, as authorized under this chapter (excluding payments to beneficiaries), may be suspended, in whole or in part, by an intermediary or a carrier when—".

§ 405.504 [Amended]

5. In paragraph (a)(1), "(see §§ 405.1684, 405.1685, and 405.1675)" is changed to "(in accordance with § 424.55 of this chapter)".

§ 405.702 [Amended]

6. In the first sentence, "(see §§ 405.1660 through 405.1674)" is removed.

§ 405.740 [Amended]

7. In paragraph (b), "§ 405.1672(a)" is changed to § 424.53 of this chapter".

§ 405.803 [Amended]

8. In paragraph (b), "405.1675" is changed to "§ 424.55 of this chapter".

§ 408.24 [Amended]

9. (Published on December 18, 1987 at 48118.)

a. In paragraph (a)(6)(ii), "section 9319(c) of Pub. L. 99–509" is changed to "section 2338(b) of Pub. L. 98–369".

b. In paragraph (a)(7)(ii), "section 9319(c) of Pub. L. 99–509" is changed to "section 2338 of Pub. L. 98–369, or section 9219(b) of Pub. L. 99–272".

§ 409.5 [Amended]

10. Reference to "Part 405, Subpart A" is changed to "Subpart H of Part 424".

§ 409.69 [Amended]

11. a. "Part 405, Subpart D" is changed to "Part 413".

b. The parenthetical statement at the end of the section is revised to read: "Rules for payment of services furnished by nonparticipating U.S. hospitals or by Canadian or Mexican hospitals are set forth in Subparts G and H of Part 424 of this chapter".

§ 410.1 [Amended]

12. In paragraph (b)—

a. In the heading and the first sentence, "subpart" is changed to "part".

b. The following is added at the end, within the parentheses:

"General conditions for Medicare payment are set forth in Part 424 of this chapter.")

§ 410.12 [Amended]

13. In paragraph (a)(3), "Subpart P of Part 405" is changed to "Subpart B of Part 424".

§ 410.14 [Amended]

14. Reference to "§ 405.153" is changed to "Subpart H of Part 424".

§ 410.40 [Amended]

15. In paragraph (d), "§ 405.153" is changed to "Subpart H of Part 424".

§ 410.60 [Amended]

16. In paragraph (a)(2), "§ 405.1634(b)(2)" is changed to "Subpart B of Part 424".

§ 410.62 [Amended]

17. In paragraph (a)(2)(iii), "§ 405.1634(b)(2)" is changed to "Subpart B of Part 424".

§ 410.150 [Amended]

18. a. In paragraph (a)(1), "Parts 405 and 416" is changed to "Parts 405, 416, and 424".

b. In paragraphs (b)(3) and (b)(4), "§ 405.1672(b)" is changed to "§ 424.53".

§ 410.152 [Amended]

19. a. In paragraph (a)(2)(i), "Parts 405 (Subpart E, P, and X) and 413 of this chapter" is changed to "Parts 405 (Subparts E and X), 413, and 424 of this chapter".

b. In paragraph (b)(3), "§ 410.168(c)" is changed to " Subpart G of Part 424 of this chapter".

c. In paragraph (i)(1)(ii), "§ 405.1675" is changed to "§ 424.55 or § 424.56"; "405.1680" is changed to "Subpart F of Part 424"; and "§ 405.1684" is changed to "§ 424.64".

§ 410.161 [Amended]

20. In paragraph (b)(3), reference to "§ 405.1684" is changed to "§ 424.64".

§ 410.168 [Amended]

21. a. In paragraph (b)(6), reference to "§ 405.191" is changed to "§ 424.103".

b. In paragraph (b)(7), reference to "§ 405.192" is changed to "§ 424.106".

c. In paragraph (c)(1), reference to "§ 405.152" is changed to "§ 424.103".

§ 410.170 [Amended]

22. a. In paragraph (b)(1), "§ 405.1633" is changed to "§ 424.22".

b. In paragraph (b)(2), "§ 405.1634" is changed to "§ 424.24".

c. In paragraph (b)(3), "§ 405.1635" is changed to "§ 424.27".

§ 410.175 [Amended]

23. In paragraph (b), "Subpart P of Part 405" is changed to "Part 424".

§ 412.20 [Amended]

24. In paragraph (b)(2), "§ 405.152" is changed to "§ 424.103".

§ 413.35 [Amended]

25. In paragraph (d) (see "§ 405.192 of this chapter)" is changed to "(as determined under § 424.106 of this chapter)".

§ 413.40 [Amended]

26. In paragraph (c)(1)(ii) "(as described in "§ 405.158(c) of this chapter)" is changed to "(as described in "§ 413.53(b))".

§ 413.74 [Amended]

27. a. In paragraph (a), "Section 405.153" is changed to " Subpart G of Part 424".

b. In paragraph (c), "§ 405.152" is changed to "§ 424.104".

§ 416.3 [Amended]

28. In paragraph (a) "§ 405.1675" is changed to "§§ 424.55 and 424.56".

§ 416.30 [Amended]

29. In paragraph (e), reference to "§ 405.1675" is changed to "§ 424.55 of this chapter", and reference to "§ 405.1684" is changed to "§ 425.64 of this chapter".

§ 416.110 [Amended]

30. In paragraph (c), "§ 405.1675" is changed to "§§ 424.55 and 424.56".

§ 417.237 [Amended]

31. In paragraph (a)(2)(iii), "Subpart P of Part 405" is changed to "Subpart B of Part 424".

§ 417.532 [Amended]

32. a. In paragraph (a)(2), "§ 405.402(a)" is changed to "§ 413.5".

b. In paragraph (e)(3), Subpart P of part 405" is changed to "Subpart B of Part 424".

§ 417.800 [Amended]

33. In paragraph (e), "§ 405.1675 of this subchapter" is changed to "§ 424.55 of this chapter".

§ 421.200 [Amended]

34. In paragraph (c)(2)(ii), "§ 405. 1675" is changed to "§ 424.55".

b. In paragraph (c)(2)(iii), §§ 405.1683 and 405.1684" is changed to "§§ 424.62 and 424.64".

§ 435.952 [Amended]

35. In paragraph (g), "Subpart P of this chapter" is changed to "Subpart P of Part 431 of this chapter".

§ 466.86 [Amended]

36. In paragraph (a)(1)(i), the words "or tuberculosis" are removed, and "§ 405.1629" is changed to "§ 424.14".

§ 482.2 [Amended]

37. In paragraph (a)(2), the last sentence is revised to read:

"Rules applicable to emergency services furnished by nonparticipating hospitals are set forth in Subapart G of Part 424 of this chapter."

§ 489.30 [Amended]

38. In paragraph (a)(4), the following is added at the end:

"with the following exception: if the DME is used DME purchased by or on behalf of the beneficiary at a price at least 25 percent less than the reasonable charge for comparable new DME, no coinsurance is required."

§ 498.3 [Amended]

39. In paragraph (b)(4), reference to "§ 405.152" is removed.

(Catalog of Federal Domestic Assistance Programs No. 13.773 Medicare—Hospital Insurance; and 13.774 Medicare—Supplementary Medical Insurance)

Dated: October 15, 1987.

William L. Roper,

Administrator, Health Care Financing Administration.

Approved: December 18, 1987.

Otis R. Bowen,

Secretary.

[FR Doc. 88-4352 Filed 3-1-88; 8:45 am]

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DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

50 CFR Part 10

Law Enforcement; Addresses of District Offices

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Final rule.

SUMMARY: The Service amends 50 CFR 10.22 to update the list of addresses of its law enforcement district offices. The title "Special Agent in Charge" has been changed to "Assistant Regional Director, Division of Law Enforcement," and the mailing address of the Washington office has a new zip code. The Service also amends the citations of the legal authority for Part 10. This rule reflects those changes.

EFFECTIVE DATE: This rule is effective on March 2, 1988.

FOR FURTHER INFORMATION CONTACT: Thomas L. Striegler, Division of Law Enforcement, Fish and Wildlife Service, U.S. Department of the Interior, P.O. Box 28006, Washington, DC 20038-8006, (202) 343-9242.

SUPPLEMENTARY INFORMATION: The Department of the Interior has determined that Executive Order 12291 and the Regulatory Flexibility Act do not apply to this action, since only titles and addresses of the Service's law enforcement offices are being changed.

Also, since this amendment's effect is purely administrative in nature and does not change agency procedure, the "notice" requirements of 5 U.S.C. 553(b) are not applicable. In addition, it is not a substantive rule requiring a delayed effective date under 5 U.S.C. 553(d).

This amendment was prepared by Margaret Culbreath Cash, Regulations Coordinator, Division of Law Enforcement.

List of Subjects in 50 CFR Part 10

Exports, Fish, Imports, Law enforcement officers, Wildlife.

PART 10—[AMENDED]

Accordingly, Part 10 of Subchapter B, Chapter I of Title 50, Code of Federal Regulations, is amended as follows:

1. The authority citation for Part 10 is revised to read as follows:

Authority: 18 U.S.C. 42; 16 U.S.C. 703-712; 16 U.S.C. 668a-d; 19 U.S.C. 1202, 16 U.S.C. 1531-1543; 16 U.S.C. 1361-1384, 1401-1407; 16 U.S.C. 742a-742j-l; 16 U.S.C. 3371-3378.

2. Section 10.1 is amended by revising the statutes listed to read as follows:

§ 10.1 Purpose of regulations.

* * * * *

Lacey Act, 18 U.S.C. 42.
Lacey Act Amendments of 1981, 16 U.S.C. 3371-3378.
Migratory Bird Treaty Act, 16 U.S.C. 703-712.
Bald and Golden Eagle Protection Act, 16 U.S.C. 668a-668d.
Endangered Species Act of 1973, 16 U.S.C. 1531-1543.
Tariff Classification Act of 1962, 19 U.S.C. 1202, [Schedule 1, Part 15D, Headnote 2(d), T.S.U.S.].
Fish and Wildlife Act of 1956, 16 U.S.C. 742a-742j-l.
Marine Mammal Protection Act of 1972, 16 U.S.C. 1361-1384, 1401-1407.

3. Section 10.22 is amended by revising the introductory text and to read as follows: the mailing address for the Washington, DC, office to read as follows:

§ 10.22 Law enforcement officers.

Service law enforcement offices and their areas of responsibility follow. Mail should be addressed: "Assistant Regional Director, Division of Law Enforcement, U.S. Fish and Wildlife Service, (appropriate address below)": "P.O. Box 28006, Washington, DC 20038-8006, Telephone: 202-343-9242."

* * * * *

Dated: February 19, 1988.

Susan Recce,

Acting Assistant Secretary for Fish and Wildlife and Parks.

[FR Doc. 88-4438 Filed 3-1-88; 8:45 am]

BILLING CODE 4310-55-M

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 672

[Docket No. 71271-8020]

Groundfish of the Gulf of Alaska

AGENCY: National Marine Fisheries Service (NMFS), NOAA, Commerce.

ACTION: Final rule.

SUMMARY: NOAA issues a final rule that amends current fishing regulations implementing the Fishery Management Plan for Groundfish of the Gulf of Alaska (FMP). This rule allows fishing in the Gulf of Alaska with pot gear for all groundfish species except sablefish. This rule is necessary to relieve an overly burdensome gear restriction of U.S. fishermen. This is a conservation and management measure intended to facilitate an orderly fishery while carrying out the Council's recommended allocation objectives in the sablefish fishery.

EFFECTIVE DATE: February 26, 1988.

ADDRESS: Copies of documents supporting this rule may be obtained from Robert W. McVey, Director, National Marine Fisheries Service, P.O. Box 1668, Juneau, AK 99802-1668.

FOR FURTHER INFORMATION CONTACT: Ronald J. Berg (Fishery Biologist NMFS), 907-586-7230.

SUPPLEMENTARY INFORMATION:

Background

The domestic and foreign groundfish fisheries in the exclusive economic zone (EEZ or 3-200 miles offshore) of the Gulf of Alaska are managed under the FMP. The FMP was developed by the North Pacific Fishery Management Council (Council) under the Magnuson Fishery Conservation and Management Act (Magnuson Act) and is implemented by regulations for the foreign fishery at 50 CFR Part 611 and for the U.S. fishery at 50 CFR Part 672.

This final rule amends a current regulation that had prohibited the use of pot gear in the Eastern and Central Regulatory Areas, and in the Western Regulatory Area after 1988, of the Gulf of Alaska while fishing for any groundfish species. Fishing with pot gear is now allowed, under this final rule, in the Eastern and Central Regulatory Areas for all groundfish species, except sablefish. Sablefish continues to be a prohibited species if caught with pot gear in these two regulatory areas. In the Western Regulatory Area, fishing